GAO

United States General Accounting Office

Report to the Honorable
Frank H. Murkowski
U.S. Senate

August 1992

VA HEALTH CARE

Offsetting Long-Term Care Costs by Adopting State Copayment Practices

GAO/HRD-92-96

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-243774

August 12, 1992

The Honorable Frank H. Murkowski
United States Senate

Dear Senator Murkowski:

This report responds to your request that we determine whether the Department of Veterans Affairs (VA) could offset more of the costs of providing nursing home and domiciliary care in VA and community facilities through increased charges to veterans.[1] As agreed with your office, we will report separately on the potential for VA to recover some of the costs of nursing home and domiciliary care from the estates of veterans or their survivors.

Background

In fiscal year 1991, VA spent about $1.3 billion to provide nursing home and domiciliary care to about 97,000 veterans. This care was provided under three VA-supported programs: (1) nursing homes and domiciliaries owned and operated by VA, (2) community nursing homes that contract with VA to provide care, and (3) state veterans' homes owned and operated by 40 states.[2] (See table 1.)

[1]Nursing homes provide care for persons who are not acutely ill or in need of hospital care but require skilled nursing care and related medical services. Domiciliaries provide shelter, food, and necessary medical care on an ambulatory self-care basis to veterans who are disabled by age or disease but not in need of skilled nursing care or hospitalization.

[2]VA contributes up to 65 percent of the cost to build or renovate state homes and pays states a daily allowance (per diem) for each eligible veteran receiving care.

Table 1: VA Expenditures for Nursing Home and Domiciliary Care, by Source of Care (Fiscal Year 1991)

Dollars in millions

Program	Number of facilities	Veterans served	VA cost
VA-owned			
Nursing homes	126	28,000	$ 744
Domiciliaries	32	19,000	168
Subtotal		**47,000**	**912**
Contract community			
Nursing homes	3,400	28,000	284
Subtotal		**28,000**	**284**
State veterans' homes			
Nursing homes	60	15,000	81
Domiciliaries	42	7,000	15
Subtotal		**22,000**	**96**
Total		**97,000**	**$ 1,292**

Veterans' eligibility for care and their out-of-pocket costs for care depend on the levels of care they need and the programs under which care is provided. All veterans with a medical need for nursing home care are eligible to receive such care in VA and community facilities to the extent that space and resources are available.[3] VA is required to collect a fee, commonly known as a copayment, from certain nonservice-connected veterans with incomes above a designated level ($18,171 for a single veteran in 1991). Nursing home care is free for other veterans who receive care in VA or contract community nursing homes (see app. II).

Eligibility for VA domiciliary care is limited to veterans with incomes below a prescribed amount ($11,409 in 1991).[4] None of these veterans, however, is required to make any copayments for domiciliary care.

Each state establishes the eligibility and copayment requirements for admission to any of its veterans' homes. VA has no direct control over admissions to state homes and pays per diem amounts only for those veterans who would be eligible for care in a VA facility. The homes may admit both veterans and nonveterans. Nonveterans may not exceed 25 percent of total residents.

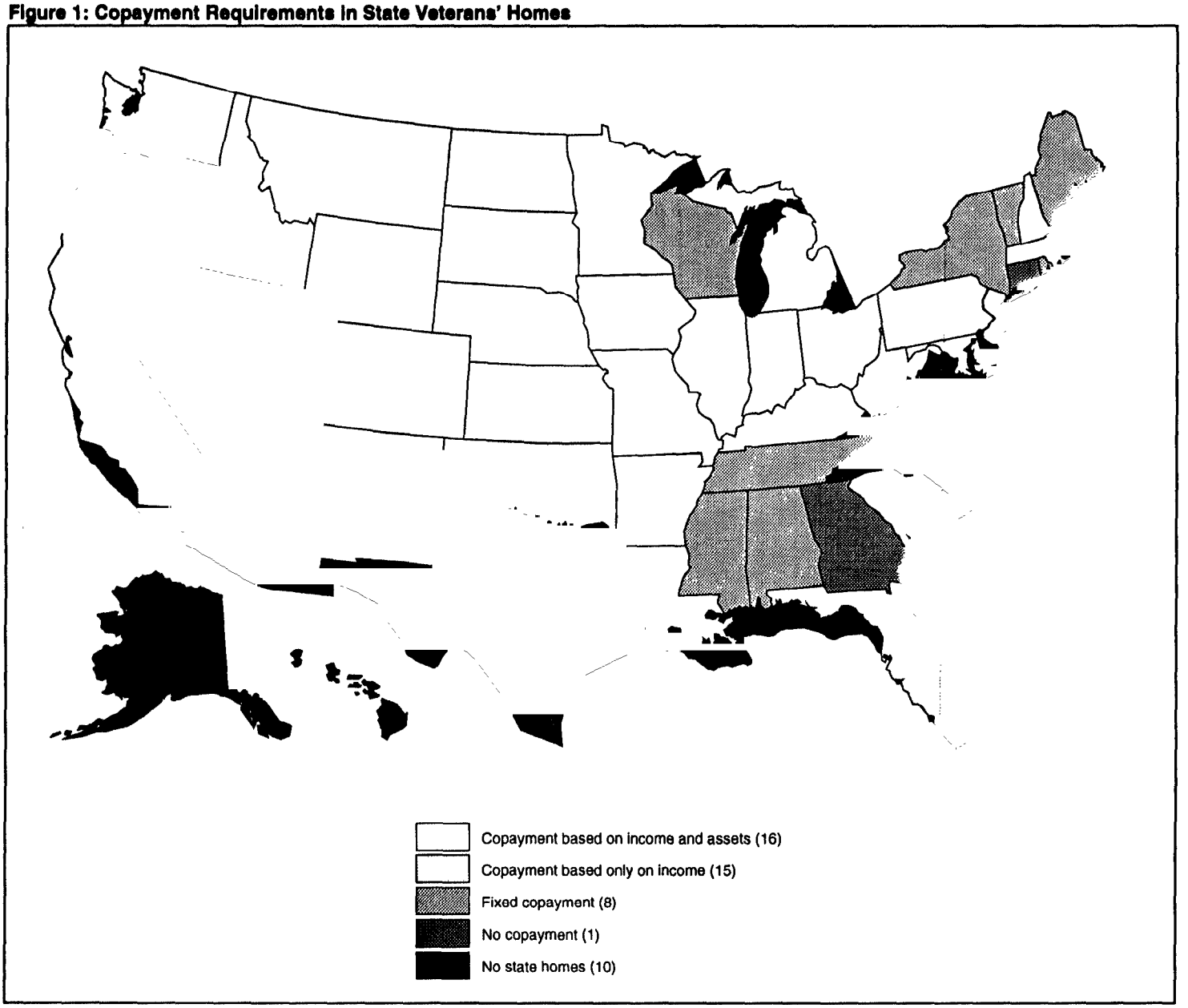
[3]Veterans who do not have a service-connected disability are limited to 6 months of care in community nursing homes. A service-connected disability is one that results from an injury or disease incurred or aggravated during active military service.

[4]The income limit is based on VA's maximum annual pension rate for single veterans needing aid and attendance.

In 1991, 39 of the 40 states with veterans homes required veterans to contribute to the cost of their care; only Georgia did not require veterans to make copayments. Of the 39 states that required copayments:

- 16 set variable copayments based on the veterans' incomes and assets;
- 15 set variable copayments based only on the veterans' incomes; and
- 8 charged a fixed copayment regardless of veterans' incomes or assets. (See fig. 1 and app. III.)

Figure 1: Copayment Requirements in State Veterans' Homes



Scope of Our Work

We compared VA nursing homes and domiciliaries and contract community nursing homes to nine state veterans' homes (in Yountville, California; Milledgeville, Georgia; Marshalltown, Iowa; Augusta, Maine; Chelsea, Massachusetts; Minneapolis, Minnesota; Truth or Consequences, New Mexico; Sandusky, Ohio; and Orting, Washington). We determined

- how much of their operating costs were offset through copayments,
- how many veterans were required to make copayments,
- how much individual veterans were required to contribute, and
- what safeguards were used to help prevent financial hardships for the veterans and their families.

See appendix I for a detailed description of our scope and methodology and the criteria used for selecting the nine state veterans' homes.

Results in Brief

VA could offset a larger portion of its nursing home and domiciliary costs if the Congress authorized it to adopt charging policies similar to those that most of the states we visited use to offset the costs of operating their state homes. In fiscal year 1990, VA offset—through copayments of $260,389—less than one-tenth of 1 percent of its costs to provide nursing home and domiciliary care in VA and community facilities. In comparison, the eight states we visited that charged for care offset from 4 to 43 percent of state home operating costs through copayments. If VA had offset similar percentages, its yearly recoveries would have been between $43 million and $464 million.

State homes offset a larger percentage of their operating costs through copayments than VA because

- more veterans are required to make copayments, and
- veterans who contribute toward the cost of their care are typically required to make larger copayments.

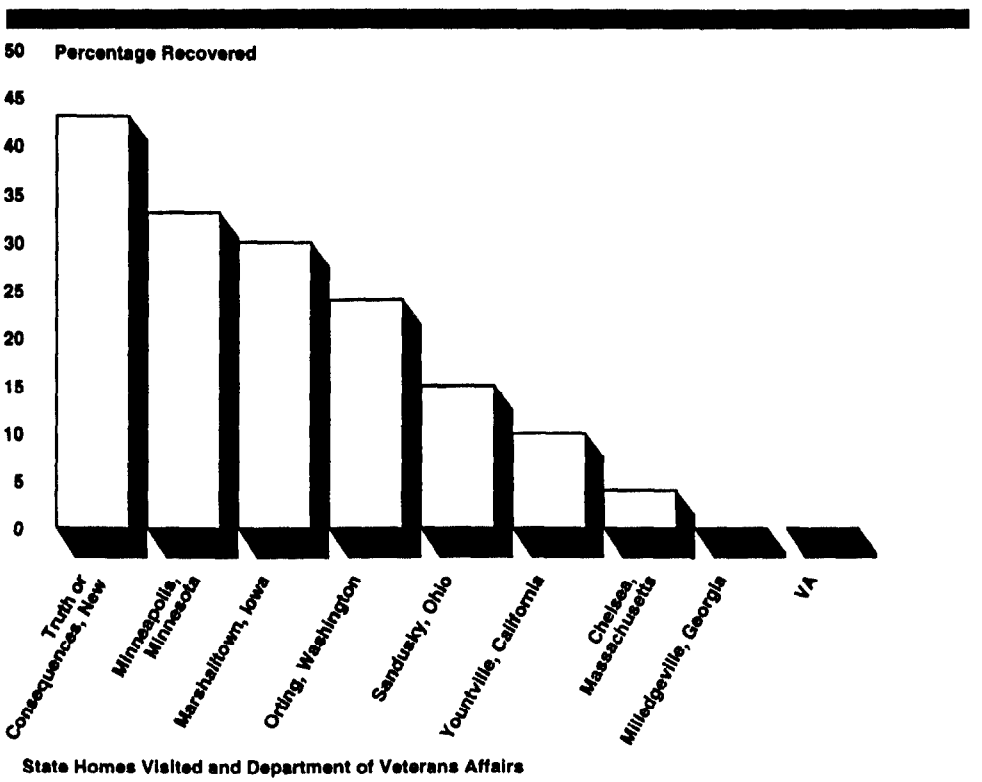
State homes also provide safeguards to help prevent copayments from impoverishing a veteran's spouse or dependent children and to help ensure that veterans capable of returning home retain sufficient financial resources to return to the community.

States Rely Much More Than VA on Copayments to Offset Costs

Faced with widening gaps between operating costs and tax revenues, many of the states we visited had implemented or increased copayments for state veterans' home residents. Although the Congress established copayments for VA and contract community nursing home care in 1986 and added an additional $5-a-day copayment in 1990, VA offsets much less of its

nursing home and domiciliary costs through copayments than eight of the nine states we visited (see fig. 2).[5]

Figure 2: Percentage of Operating Budget Recovered From Veterans in FY 1990 (by State Homes and VA)



GAO calculated these percentages from data provided by state home and Department of Veterans Affairs officials.

The Augusta, Maine, home was excluded because the home could not separate veterans' copayments from Medicaid reimbursements; therefore, we did not calculate the percentage recovered through veterans' copayments.

Note: Because of the unique way in which its state home's operating costs are financed, Maine officials were unable to estimate the percentage of operating costs offset through copayments. Maine does not directly appropriate any funding to support the home's operation. Instead, the home is supported through (1) VA per diem payments, (2) Medicaid, and (3) veteran copayments.

[5]Includes recoveries from nonveterans in California (1 percent of home's residents), Minnesota (3 percent), New Mexico (6 percent), Iowa (12 percent), Washington (14 percent), and Maine (25 percent). The homes were unable to separate amounts collected from veterans and nonveterans.

In 1981, we reported that many state homes were offsetting a portion of their operating costs through nongovernment sources, primarily through charges to veterans, but that there were opportunities to increase the charges.[6] We concluded that states should take full advantage of other sources of revenue, including charges to veterans, before seeking additional federal funding to help offset increasing state home operating costs.

Since 1983, five of the nine state homes we visited during our current review had either implemented or were considering implementing new policies on veteran copayments. Two of the states—Massachusetts and New Mexico—did so to avoid closing their state homes.

Massachusetts did not require veterans to contribute to the cost of their care until August 1990. The Chelsea state home commandant told us that the state home was faced with closure due to a $700,000 shortfall in state funding. Veterans' service organizations, he said, were initially opposed to copayments. To avoid closure of the home, however, the veterans' groups subsequently agreed to copayments set just high enough to cover the budget shortfall.

Although the Chelsea home offset only 4 percent of its fiscal year 1990 costs through copayments from veterans, its copayment collections ($674,418) were still more than twice VA's nursing home collections nationwide ($260,389). If VA, like the Chelsea home, had recovered 4 percent of its costs in fiscal year 1990, it would have offset $43 million of its nursing home and domiciliary costs.

Like the Massachusetts home, the New Mexico state home at Truth or Consequences faced possible closure in late 1989 because of state budget shortfalls. Although the state had charged veterans for their care since the state home opened in early 1986, it believed the lack of a uniform policy for determining veterans' copayments was limiting the state's ability to offset the home's operating costs.

In January 1990, New Mexico implemented more stringent, uniform rules on allowable income and asset exemptions and a standard method to determine veterans' copayment amounts. These new rules allowed New Mexico to offset 43 percent of the operating costs of the Truth or Consequences home through copayments in fiscal year 1990. If VA, like the

[6]State Veterans' Homes: Opportunities to Reduce VA and State Costs and Improve Program Management (GAO/HRD-82-7, Oct. 22, 1981).

New Mexico home, had offset 43 percent of its 1990 nursing home and domiciliary costs through copayments, it would have recovered $464 million.

Georgia, like Massachusetts and New Mexico, is facing serious budgetary problems. Currently the only state that does not require copayments, Georgia is considering adopting a copayment policy.

In Ohio, state home officials told us that their home began operating more self sufficiently in July 1983 by shifting more of the cost burden to veterans. Collections from veterans were earmarked for capital and equipment purchases, reducing dependence on state funding. In addition, the state expanded its capacity to care for veterans by using veteran copayments as matching funds to secure a VA construction grant for an addition to the state home.

Finally, since it opened its first state home in 1983, Maine has required veterans to make significant copayments. Every resident in the Maine state home is expected to pay a flat rate, which is the difference between the cost of care and the VA per diem payment, out of his or her own resources. Veterans who do not have sufficient resources to pay for their care must apply for Medicaid. The Medicaid program then pays the difference between what the veteran was charged for care and what the veteran was able to pay. At the time of our visit in June 1991, about two-thirds of the residents were receiving Medicaid assistance.

Although VA, like the states, is facing steadily increasing costs under its nursing home and domiciliary programs, it has not focused on veterans as a potential source of revenues for offsetting those costs. In its November 1991 report, however, VA's Commission on the Future Structure of Veterans Health Care said that it would be difficult, if not impossible, in the long run to obtain significant increases in funds through direct appropriations. Although the report recommended that VA pursue other sources of funding, such as recoveries from other federal health programs, it did not explore veteran copayments as a potential source of revenues.

State Homes Exempt Fewer Veterans From Copayments Than VA

At seven of the eight state homes we visited that require veterans to contribute to the cost of their care, over 90 percent of the veterans made copayments in fiscal year 1991. By contrast, only about 1 percent of veterans discharged from VA and contract community nursing homes and domiciliaries were subject to copayments.[7] This is because (1) VA exempts many veterans from copayments on grounds other than financial criteria, whereas the states used only financial criteria, and (2) VA uses more generous financial criteria for determining the veteran's ability to make copayments than the states we visited.

VA exempts three groups of veterans from copayments based on nonfinancial criteria:

- Domiciliary residents (about 18 percent of long-term care patients);
- Service-connected veterans (43 percent of nursing home patients discharged from VA and community nursing homes in 1991) even if the treatment is unrelated to their service-connected disability; and
- All veterans who were former prisoners of war; served in the Mexican border period or World War I; or were exposed to certain toxic substances or radiation and need treatment for related conditions (these groups combined represent less than 1 percent of the veterans discharged from VA and community nursing homes in 1991).

Although the eight states, like VA, exempt from copayments those veterans whose financial resources were below some designated level, they used stricter financial criteria in determining a veteran's ability to make copayments. In fiscal year 1991, about 55 percent of the veterans discharged from VA nursing homes and contract community nursing homes were considered unable to pay. Of these, 17 percent were automatically classified as unable to pay because their incomes were low enough to qualify for a VA pension.[8] The remaining 38 percent were considered unable to pay because they were either Medicaid-eligible or had total financial resources below a statutorily designated level that would require them to make copayments, but above the level needed to qualify for a VA pension or Medicaid. For example, a veteran with no dependents, no liquid assets,

[7]This section discusses veterans discharged from VA and community nursing homes rather than veterans treated in these facilities. VA could not provide data on veterans treated in 1991 by copayment status, disability, service history, or ability to pay, but could provide these data for veterans discharged. The data include veterans discharged to home and other care facilities, and veterans who died.

[8]The VA pensions of veterans without dependents are reduced to not more than $90 per month 3 months after admission to a VA nursing home or domiciliary or a community nursing home. VA pensions are not reduced for veterans entering state veterans' homes and are generally included in the veterans' income for purposes of establishing copayments.

and an annual income up to $18,171 would not be required to pay a copayment for VA nursing home care. The income level is adjusted upward for veterans with dependents.

None of the state homes we visited automatically classifies a veteran as unable to pay if he or she receives a VA pension or is eligible for Medicaid. For example, Massachusetts and Ohio require single veterans to make at least minimal copayments ($5 or less) if their annual incomes exceed $2,400 and $1,080, respectively.

To demonstrate the effect of the VA exemptions on potential recoveries, we asked officials at the eight state homes to estimate the copayments they would have charged to three hypothetical veterans who would be exempt from copayments if they obtained care in VA or community nursing homes. After combining the required copayments for the three veterans as a group, at the eight state veterans' homes, the total daily copayments for the three veterans ranged from $15 in Massachusetts to $145.11 in Iowa. (See pages 17 and 26.)

States Generally Set Higher Copayments Than VA

States generally require veterans to make higher copayments for care provided in their state veterans' homes than VA requires for care in VA and community nursing homes. In 1991, those veterans required to contribute toward the cost of care in VA or community nursing homes or domiciliaries paid a flat rate equivalent to $11.98 daily.[9] In comparison, as shown in table 2, the maximum daily rate for nursing home care in the eight state homes ranged from $5 in Massachusetts to $92.56 in New Mexico. As discussed earlier, Maine charged a flat rate to all veterans; the other homes charged veterans using a sliding scale based on income, assets, or both. Appendix IV discusses the systems used by VA and the eight state homes to determine ability to pay and the methods used to set copayment amounts.

[9]VA charges a flat fee of $628 for every 90-day period of nursing home care plus a daily charge of $5. We calculated the maximum daily rate for a 90-day period as follows:[[$628 + ($5 x 90)]/90] or $11.98 per day.

Table 2: Maximum Daily Copayments for Nursing Home Care

Veterans' home	Maximum daily copayment
Truth or Consequences, NM	$92.56
Minneapolis, MN	90.60
Orting, WA	79.40
Augusta, ME	77.56
Marshalltown, IA	66.14
Yountville, CA	29.59
Sandusky, OH	18.74
Chelsea, MA	5.00[a]
VA	11.98

[a]To the extent that the veteran has available income, the Chelsea home charges copayments of $15 a day for its "hospital" level of care, recognized by Medicare as skilled nursing home care, and $5 a day for other nursing home care.

To demonstrate the effect of the difference in copayment amounts, we asked officials at VA and the eight state veterans' homes to estimate the daily copayments for three hypothetical veterans who would have been subject to the $11.98 daily copayment in VA and community nursing homes, for a total daily copayment for the three veterans as a group of $35.94. After combining the required copayments for the three veterans as a group, seven of the eight state veterans' homes would have required the veterans to make higher copayments, ranging from $48.77 in Ohio to $271.80 in Minnesota. At the eighth state home, in Chelsea, Massachusetts, the copayments for each of the three veterans would have ranged from $5 to $15 per day depending on the level of nursing home care provided. (See pages 17 and 26.)

States Have Safeguards to Protect Veterans and Their Families

Each of the eight states we visited that charge veterans for their nursing home and domiciliary care used three primary safeguards to prevent such charges from causing undue financial hardship on the veterans or their families.[10] First, none of the states require veterans to sell their homes if there is a reasonable expectation that the veteran will be able to return home or if the veteran has a spouse living in the home. In Iowa and Minnesota, however, a single veteran with no prospect of returning home must sell or rent his or her residence and apply the proceeds toward the copayment amount.

[10]Maine relies on the safeguards established under the state's Medicaid program.

Second, all eight states exclude a specified amount of the veteran's monthly income from the copayment computation as a personal needs allowance. Exclusions for personal needs allowances range from $30 in New Mexico to $200 in Massachusetts. Additional amounts of the veteran's income are excluded from the copayment computation in some states to allow veterans to pay health insurance premiums (Minnesota, New Mexico, and Ohio), make court ordered payments (California, Iowa, Massachusetts, Minnesota, and New Mexico), and/or pay other outstanding bills (Minnesota).

Finally, each state has provisions to protect the veteran's spouse from impoverishment. In addition to excluding the principal residence, each state excludes a portion of the veteran's income from the copayment computation. For example, Ohio permits the spouse to retain 50 percent of the veteran's income. Similarly, California permits the spouse to retain a portion of the veteran's income to meet the estimated living expenses of the household, including dependents. Although New Mexico includes the income and liquid assets of both the veteran and his or her spouse in the copayment computation, it exempts over 95 percent of the couple's liquid assets and 50 percent of their joint income from the copayment computation.

Conclusions and Matters for Consideration by the Congress

Federal and state governments are facing mounting budget deficits at the same time that health care costs continue to rise. In such an environment, the ability of governments to maintain current programs, let alone expand to serve an increasing aging population, is severely strained. To address these pressures, state governments, more than the federal government, require veterans to contribute to the cost of nursing home and domiciliary care.

The Congress may wish to consider changing the current policy for charging veterans for care in VA and community facilities to help offset increased operating costs, fund care for more veterans, or both. The Congress also may wish to consider changing the copayment requirements by discontinuing automatic exemptions for certain types of veterans. Yet another option the Congress may wish to consider is increasing the amount of the copayment by instituting a higher fixed rate copayment or a variable rate copayment based on the veteran's ability to pay. Any change in the law should be accompanied by adequate safeguards to help prevent placing an undue financial hardship on the veterans or their families.

Agency Comments

The Secretary of Veterans Affairs, in a letter dated July 6, 1992, said that all avenues, including increased cost sharing, that could offer solutions to the increasing escalation of costs for all types of medical care should be explored. VA said that the use of copayments as a means to provide less costly care will be carefully scrutinized as VA reviews eligibility reform.

VA agreed with our conclusions that any expansion of the current copayment criteria would require congressional action and that any such action should be accompanied by adequate safeguards to help prevent placing an undue financial hardship on the veterans or their families.

Unless you publicly announce its contents earlier, we plan no further distribution of this report for 30 days. At that time we will send copies to the Secretary of Veterans Affairs and interested congressional committees. We will also make copies available to others upon request.

This report was prepared under the direction of David P. Baine, Director, Federal Health Care Delivery Issues. If you have any questions you can call him on (202) 512-7101. Other major contributors are listed in appendix VII.

Sincerely yours,

Lawrence H. Thompson

Lawrence H. Thompson
Assistant Comptroller General

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Abbreviations

GAO	General Accounting Office
VA	Department of Veterans Affairs

Scope and Methodology

To select the states for our field work, we obtained a directory of state veterans' homes from the National Association of State Veterans' Homes and contacted state home officials in each of the 38 states operating state homes at that time. We then determined if veterans were required to make copayments for nursing home care and, if so, how the amount of the copayment was set.[1]

From the 32 states that charge copayments for nursing home care,[2] we judgmentally selected eight states that represented the different copayment bases and visited one state home in each state. We also visited a state home in Georgia, the only state that does not require any veterans to pay for nursing home or domiciliary care. (See table I.1 for the states we visited.)

Table I.1: State Veterans' Homes Visited, by Copayment Base

Copayment	State veterans' home
Variable—based on income	Yountville, CA Chelsea, MA Sandusky, OH Orting, WA
Variable-based on income and assets	Marshalltown, IA Minneapolis, MN Truth or Consequences, NM
Fixed—regardless of income or assets	Augusta, ME
No copayment—regardless of income or assets	Milledgeville, GA

At the nine state homes, we interviewed officials to discuss the operation of the state home and how much of their operating costs are recovered from veterans. These officials provided data on their fiscal year 1990 operating costs and copayment collections, and from these data we calculated the percentage of operating budgets recovered from veterans. We did not verify the accuracy of the data provided by the state home officials. To accomplish the other three objectives—determining which veterans are required to pay, the methods used to determine how much a veteran pays, and the safeguards used to prevent financial hardships—we interviewed state home officials and obtained copies of the state homes' rules and regulations. We also asked the state home officials to calculate

[1]Tennessee and Kentucky opened state veterans' homes after we made our site selections.

[2]We focused on the 32 states that provide nursing home care because VA provides nursing home care to more veterans and spends more on this care than on domiciliary care.

the daily charge for six hypothetical veterans[3] representing various financial and service-related situations. (See appendix V for details on these hypothetical scenarios.)

To obtain information on VA's policies for charging veterans and its cost recovery efforts, we reviewed VA laws, regulations, rules and directives, and interviewed VA headquarters officials in the Medical Administrative Services, the Medical Care Cost Recovery and the Geriatrics and Extended Care offices. We also met with VA officials at the Des Moines and Atlanta VA medical centers.

Our review was performed from May 1991 to January 1992 in accordance with generally accepted government auditing standards.

[3]Three of the hypothetical veterans would not be required to make a copayment to VA for nursing home care (Veteran 1, 4, and 6). The other three (Veteran 2, 3, and 5) would be required to make copayments.

Legislative Authority for VA's Copayment Requirements

The Veterans Health Care Amendments of 1986 (Public Law 99-272) require VA to collect a fee, commonly referred to as a copayment, from certain veterans who receive nursing home care in VA's own facilities or in community nursing homes under VA contract. The requirement applies to any veteran, unless he or she meets at least one of the following criteria:

- has a service-connected disability;
- is a former prisoner of war;
- is a veteran of the Mexican border period or World War I;
- was exposed to certain toxic substances or radiation and needs treatment for related conditions; or
- has a nonservice-connected disability and is unable to defray the cost of care. Veterans eligible for Medicaid, receiving a VA pension,[1] or having financial resources below a prescribed level (see app. IV for discussion on the prescribed resource level) are considered unable to defray the cost of care.

The law specifies that veterans not meeting these criteria must agree to pay, for each 90 days of nursing home care, an amount equal to Medicare's inpatient deductible. In fiscal year 1991, these veterans were required to pay $628 for each 90 days of care in a VA nursing home or contract community nursing home.

The Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) expanded the copayment requirements for veterans not meeting one of the criteria that exempts veterans from copayments. In addition to the 90-day period copayment required under the 1986 law, these veterans are required to pay an additional $5 for each day of nursing home care in a VA nursing home or contract community nursing home.

[1]Veterans receiving VA pensions are not required to pay for their care. However, under 38 C.F.R. 3.551, the pensions of veterans without dependents are reduced to not more than $90 per month 3 months after admission to a VA nursing home. The pensions of veterans in VA domiciliaries and community nursing homes are also reduced. The pensions of veterans in state veterans homes are not reduced.

Basis for Setting Copayments in State Veterans Homes

State	Number of homes	Care provided[a]	Copayment basis[b]
Alabama	1	NH	Fixed fee
Arkansas	1	NH & DOM	Variable/income & assets[c]
California	1	NH & DOM[d]	Variable/income only
Colorado	3	NH & DOM	Variable/income & assets[c]
Connecticut	1	DOM[d]	Variable/income & assets
Florida	1	DOM	Variable/income only
Georgia	2	NH & DOM	No copayment
Idaho	1	NH & DOM	Variable/income & assets
Illinois	3	NH & DOM	Variable/income only
Indiana	1	NH & DOM	Variable/income & assets
Iowa	1	NH & DOM[d]	Variable/income & assets
Kansas	1	NH & DOM	Variable/income only
Kentucky	1	NH	Variable/income & assets
Louisiana	1	NH & DOM	Variable/income & assets
Maine	3	NH	Fixed fee
Maryland	1	NH & DOM	Fixed fee[c]
Massachusetts	2	NH & DOM[d]	Variable/income only
Michigan	2	NH & DOM	Variable/income & assets
Minnesota	2	NH & DOM	Variable/income & assets
Mississippi	1	NH	Fixed fee
Missouri	4	NH	Variable/income & assets
Montana	1	NH & DOM	Variable/income & assets
Nebraska	4	NH & DOM	Variable/income & assets
New Hampshire	1	NH	Variable/income only
New Jersey	3	NH & DOM	Variable/income only
New Mexico	1	NH & DOM	Variable/income & assets
New York	1	NH	Fixed fee
North Dakota	1	DOM	Variable/income only
Ohio	1	NH & DOM	Variable/income only
Oklahoma	6	NH & DOM	Variable/income only
Pennsylvania	3	NH & DOM	Variable/income only
Rhode Island	1	NH & DOM	Variable/income only
South Carolina	2	NH	Variable/income only
South Dakota	1	NH & DOM	Variable/income & assets
Tennessee	1	NH	Fixed fee
Vermont	1	NH & DOM	Fixed fee
Washington	2	NH & DOM	Variable/income only

(continued)

State	Number of homes	Care provided[a]	Copayment basis[b]
West Virginia	1	DOM	Variable/income only
Wisconsin	1	NH & DOM	Fixed fee
Wyoming	1	DOM	Variable/income & assets

Source: Discussions with state veterans homes officials in each state.

[a]The type of care provided is nursing home (NH) and/or domiciliary (DOM).

[b]Unless otherwise noted, states providing nursing home and domiciliary care use the same copayment basis for both types of care.

[c]Domiciliary copayments are based on income only.

[d]This state also provides some limited care that VA recognizes as acute (hospital) care.

Comparison of the Systems Used by VA and the Eight States Visited by GAO to Assess Ability to Pay

VA's System for Determining Ability to Pay

Certain veterans are automatically eligible for free care from VA and make no copayments. If a veteran does not automatically qualify for free care, VA must assess the veteran's income and assets and his or her family's income to determine whether a copayment is required.

To determine ability to pay, VA first determines the income of the veteran, the veteran's spouse, and any dependents. The types of income include Social Security benefits, U.S. Civil Service retirement, U.S. Railroad Retirement, military retirement, unemployment insurance, any other retirement income, total wages from all employers, interest and dividends, workers' compensation, black lung benefits, and any other income from the calendar year prior to the veteran's application for care.

If the income is greater than a prescribed amount, the veteran must pay the copayment. In 1991, the prescribed income threshold was $18,171 for veterans with no dependents. The threshold is adjusted upward for each dependent. Regardless of how much any veteran's income exceeds the limit, each veteran pays $628 per 90-day period of nursing home care, plus $5 per day.

If the veteran's income is below the prescribed threshold, VA will review the veteran's income and assets to determine his or her ability to pay. The types of assets included in the assessment are stocks, bonds, notes, individual retirement accounts, bank deposits, savings accounts, and cash. Primary residence and personal property are excluded. The veteran's debts are subtracted from the market value of the assets to determine net worth. If the sum of the veteran's annual income and net worth exceeds $50,000, the veteran must pay the copayment. However, the veteran's case will be reviewed periodically by VA to determine if the veteran must continue to make copayments. If the sum of the veteran's income and net worth is $50,000 or less, the veteran is not required to make copayments.

Systems Used by the Eight States to Determine Ability to Pay

Table IV.1 summarizes the main features of the systems used by the states to assess whether a veteran has the ability to pay and to set the amount of the veteran's copayment.

Table IV.1: State Homes' Systems for Determining Ability to Pay and to Compute Veterans' Copayments for Nursing Home Care

	State							
	CA	IA	ME[a]	MA	MN	NM	OH	WA
Income counted toward copayment								
Veteran's income[b]	X	X	X	X	X	X	X	X[m]
Spouse's income[b]						X		
Assets counted toward copayment								
Veteran's liquid assets[c]		X	X[d]		X	X[e]		
Veteran's real property		X[f]	X[f]		X[f]			
Spouse's liquid assets[c]			X[g]			X		
Income Allowances								
Veteran's personal needs	X[h]	X[h]	X[h]	X[h]	X[h]	X[h]	X[h]	X[h]
Spouse's living expenses	X[i]	X[i]	X[k]	X[l]	X[i]	X[i]	X[j]	X[i]
Veteran's health insurance premiums			X		X	X	X	
Veteran's court ordered payments	X	X		X	X	X		
Ceiling on amount of copayment[n]	X	X	X	X	X	X	X	X

(Table notes on next page)

[a]This column shows the types of income, assets, and safeguards contained in the Maine Medicaid program.

[b]Income includes items such as wages, VA compensation, VA pension, Social Security benefits, any other retirement income, interest income, and rental income.

[c]Liquid assets include such items as checking and savings accounts and stocks and bonds.

[d]Up to 50 percent of liquid assets are exempt.

[e]New Mexico exempts $2,000 of liquid assets for the veteran and $2,000 for the spouse. Of the remaining liquid assets, only 5 percent is counted in the copayment calculation.

[f]The residence is considered only in the case of a veteran with no dependents or no prospect of returning home. Such a veteran must rent or sell the residence to convert it into income or a liquid asset, which is counted in the copayment computation.

[g]The Maine Medicaid program considers the total assets of the Medicaid recipients and their spouses, but the spouses are provided an asset allowance.

[h]To provide for the veteran's personal needs, the veteran may retain $150 per month in California; $40 in Maine; $200 in Massachusetts; $85 in Minnesota; $30 in New Mexico; $90 in Ohio; and $182 in Washington. In Iowa, the personal allowance is a percentage of the veteran's income.

[i]The veteran retains a portion of his income to meet the reasonable living expenses for the spouse and any dependents.

[j]In Iowa, 50 percent of the veteran's income is retained for the spouse or a dependent; in Ohio, 50 percent is retained for the spouse or a dependent, 65 percent for two dependents, or 75 percent for three or more dependents; in New Mexico, 50 percent of the couple's joint income is retained for the spouse.

[k]The veteran retains enough income to assure the spouse a monthly income not to exceed $1,662 in 1991.

[l]The Chelsea home has 68 beds that meet VA's definition of nursing home beds for which the home charges up to $5 a day. The home has an additional 88 beds that are certified by Medicare as skilled nursing facility beds for which the home charges up to $15 a day. No spousal living allowance is given if the veteran occupies a $5 bed; however, a monthly allowance of $800 is given for the spouse if the veteran occupies a $15 bed.

[m]Although the Washington home considers only income in setting the copayment, the home admits only those veterans whose liquid assets and real property are valued at less than $1,600.

[n]The daily copayment ceiling is equal to or less than the daily cost of nursing home care. See table 2 for each state homes' maximum daily rate for nursing home care.

The following hypothetical examples illustrate the methods and safeguards used by two states—Ohio and New Mexico—to compute the copayments. We asked the states to compute copayments for two hypothetical veterans.[1] As shown in table IV.2, in Ohio, the first veteran's total monthly income is reduced by one-half to allow for the spouse's

[1]As discussed previously, we asked each state home to apply their copayment computation methods to six hypothetical veterans. The first veteran in the Ohio and New Mexico examples is hypothetical veteran 1, and the second veteran is hypothetical veteran 4. The hypothetical veterans are described in appendix V.

living expenses, and then a $90 monthly personal allowance for the veteran is subtracted. The remainder ($383) is the first veteran's monthly copayment. The second veteran, on the other hand, is not married; therefore, his or her total monthly income is reduced only by the $90 monthly personal allowance. Although this leaves $1,202 available for monthly copayments, no veteran's monthly copayment in Ohio can exceed $570; therefore, the second veteran retains all income over $570. If either veteran had been paying health insurance premiums, the countable income would have been further reduced by the amount of the premiums.

Table IV.2: Copayment Computation for Two Hypothetical Veterans for the Ohio Veterans' Home

Income/asset considered	First veteran	Second veteran
Veteran's monthly income	$946.67	$1,292.00
Less 1/2 for spouse	–473.34	0.00
Less $90 monthly allowance	–90.00	–90.00
Countable income remaining	383.33	1,202.00
Monthly copayment	383.33	570.00
Monthly income remaining after copayment and retained by veteran	0.00	632.00

As shown in table IV.3, in New Mexico the liquid assets of the first veteran are reduced by $2,000 for both the veteran and the spouse. After this reduction, 5 percent of the liquid assets is counted as potentially available for copayments, and this amount is added to the income of the veteran and spouse. Their combined countable income and assets are then reduced by one-half to allow for the spouse's living expenses. The remaining amount is reduced by the $30 monthly personal allowance, and the remainder after this reduction is the first veteran's monthly copayment. Because the second veteran is not married, he or she is allowed only a $2,000 reduction in assets, and the total income and assets are not reduced by one-half. If either veteran had been paying health insurance or court-ordered payments, the countable income would have been reduced by those amounts. Additionally, if either veteran's monthly countable income and assets exceeded $2,815 (the maximum monthly copayment), the veteran would retain all income in excess of the maximum.

Table IV.3: Copayment Computation for Two Hypothetical Veterans for the New Mexico Veterans' Home

Income or Asset Considered	First veteran	Second veteran
Total liquid assets	$10,000.00	$ 3,400.00
Less $2,000 exemption	–4,000.00	–2,000.00
Liquid assets after exemption	6,000.00	1,400.00
5 percent of liquid assets	300.00	70.00
Veteran's monthly income	+946.67	+1,292.00
Spouse's monthly income	+1,008.33	+0.00
Combined income and assets	2,255.00	1,362.00
Less 1/2 for spouse	–1,127.50	–0.00
Less $30 monthly allowance	–30.00	–30.00
Countable assets and monthly income	1,097.50	1,332.00
Monthly copayment	1,097.50	1,332.00

Scenarios for Six Hypothetical Veterans

To meet our objectives and help ensure data comparability, we asked state home officials to calculate the daily charge for the following six scenarios representing various financial and service-related situations.

Veteran 1

Age: 58 years old.

Marital status: Married with one dependent (spouse). Spouse resides in residence.

Disability: Service connected disability—10-percent rating. Receives VA compensation.

Financial Information			
Annual Income	Veteran	Wages ($500/month) earned in past year—no longer capable of earning wages	$ 6,000
		Retirement ($850/month)	10,200
		VA compensation ($80/month)	960
		Annual interest income	200
	Spouse	Wages ($1,000/month)	12,000
		Annual interest income	100
Assets	Joint	Value of residence (no outstanding debt)	50,000
		Checking and savings accounts	10,000
Debts	Joint	Current outstanding credit card debt	600
		Health insurance premium for spouse ($30/month)	360
		Household expenses ($200/month)	2,400

Veteran 2

Age: 58 years old.

Marital status: Married with one dependent (spouse). Spouse resides in residence.

Disability: Nonservice-connected disability. Does not receive a VA pension.

Financial information			
Annual income	Veteran	Wages ($500/month) earned in past year—no longer capable of earning wages	$ 6,000
		Retirement ($850/month)	10,200
		Annual interest income	
	Spouse	Wages ($1,000/month)	
		Annual interest income	100
Assets	Joint	Value of residence (no outstanding debt)	50,000
		Checking and savings accounts	10,000
Debts	Joint	Current outstanding credit card debt	600
		Health insurance premium for spouse ($30/month)	360
		Household expenses ($200/month)	2,400

Veteran 3

Age: 68 years old.

Marital Status: Never married, no dependents.

Disability: Nonservice-connected disability. Does not receive a VA pension.

Financial information			
Annual income	Veteran	Retirement ($900/month)	$10,800
		Social Security ($500/month)	6,000
		Annual interest income	500
Assets	Veteran	Does **not** own a home	
		Stocks and bonds	20,000
		Checking and savings accounts	13,000
Debts		None	

Veteran 4

Age: 74 years old.

Marital status: Never married, no dependents.

Disability: Nonservice-connected disability. Does not receive a VA pension.

Financial information			
Annual income	Veteran	Retirement ($750/month)	$ 9,000
		Social Security ($500/month)	6,000
		Annual interest income	500
Assets	Veteran	Does **not** own a home	
		Stocks and Bonds	1,400
		Checking and savings accounts	2,000
Debts		None	

Veteran 5

Age: 70 years old.

Marital status: Never married, no dependents.

Disability: Nonservice-connected disability. Does **not** receive a VA pension.

Financial information			
Annual income	Veteran	Retirement ($1,000/month)	$12,000
		Social Security ($650/month)	7,800
		Annual interest income	500
Assets	Veteran	Does **not** own a home	
		Stocks and bonds	2,000
		Checking and savings accounts	5,000
Debts		None	

Veteran 6

Age: 81 years old.

Marital status: Widow/widower, no dependents.

Disability: Nonservice-connected disability. Receives a VA pension.

Financial Information

Annual income	Veteran	Social Security ($450/month)	$ 5,400
		Annual VA pension	1,733
Assets		None	
Debts		None	

Comments From the Department of Veterans Affairs

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

JUL 6 1992

Mr. David P. Baine
Director, Federal Health Care
Delivery Issues
Human Resources Division
U. S. General Accounting Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Baine:

I have reviewed your draft report, **VA HEALTH CARE: Offsetting Long-term Care Costs By Adopting State Copayment Practices** (GAO/HRD-92-96). I agree with your conclusion that if VA is to expand current copayment criteria, Congress will have to enact legislation allowing such action. Also, I strongly support GAO's conclusion that any change in policy should be accompanied by adequate safeguards to help prevent placing an undue financial hardship on the veterans or their families.

As the report states, VA is legislatively mandated to exclude certain categories of patients from making copayments for their care. All veterans with a medical need for nursing home care are eligible to receive such care in VA operated nursing homes to the extent that space and resources are available. Eligibility for non-service connected veterans to receive care in Community Nursing Homes sponsored by VA is generally limited to six months and only if they are transferred from a VA health-care facility. Service-connected veterans, and certain non-service connected veterans, e.g., World War I and former POWs, by law, make no copayments and have the highest priority in nursing home placements. Non-service connected veterans whose incomes require that they make a copayment are in the lowest priority group for nursing home placement. The amount of copayment is established by law and is based on income limitations as well as eligibility criteria. Unless Congress acts to change the law, VA must continue to provide care within the current eligibility and copayment criteria.

I recognize the issue of cost sharing is an important one. The increasing escalation of costs for all types of medical care necessitates that we examine all avenues that could offer solutions. The Department is reviewing eligibility reform and will carefully scrutinize the issue of copayments as a means to provide less costly care.

Thank you for the opportunity to comment on this report.

Sincerely yours,

Edward J. Derwinski

EJD/vz

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