



Who Pays for Long-Term Services and Supports?

Long-term services and supports (LTSS) refers to a broad range of health and health-related services and other types of assistance that are needed by individuals over an extended period of time. The need for LTSS affects persons of all ages and is generally measured by limitations in an individual’s ability to perform daily personal care activities such as eating, bathing, or dressing. The probability of needing LTSS increases with age. As the nation’s population aged 65 and older continues to increase in size, and individuals continue to live longer post-retirement, the demand for LTSS is also expected to increase. In addition, advances in medical and supportive care may allow younger persons with disabilities to live longer. For more information, see CRS In Focus IF10427, *Overview of Long-Term Services and Supports*.

CRS analyzed data by the Centers for Medicare & Medicaid Services (CMS) National Health Expenditure Account (NHEA) to examine LTSS spending by payer. This analysis includes Medicare post-acute care spending for home health and skilled nursing facility care in an expanded definition of LTSS spending. Using this definition, total U.S. spending on LTSS is a significant component of all personal health care spending. In 2018, an estimated \$409.2 billion was spent on LTSS, representing 13.3% of the \$3.1 trillion spent on personal health care.

LTSS payments include those made for services in nursing facilities and in residential care facilities for individuals with intellectual and developmental disabilities, mental health conditions, and substance abuse issues. LTSS spending also includes payments for services provided in an individual’s own home, such as personal care and homemaker/chore services (e.g., housework or meal preparation), as well as a wide range of other community-based services (e.g., adult day health care services). Given that a substantial amount of LTSS is also provided by family members, friends, and other uncompensated caregivers. Thus, formally reported spending on LTSS underestimates total expenditures, as spending data do not include uncompensated care provided by these caregivers. This report provides information on who the primary LTSS payers are and how much they spend.

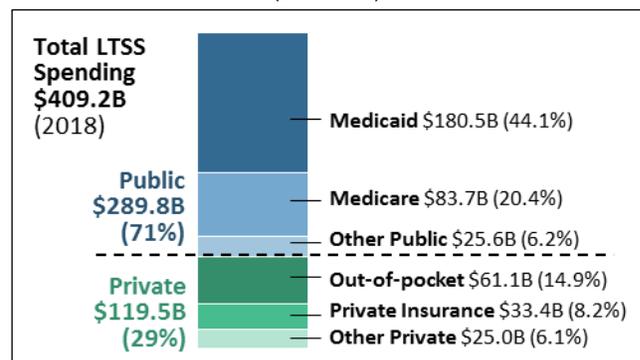
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LTSS are financed by a variety of public and private sources. **Error! Reference source not found.** shows LTSS spending by payer for 2018. Public sources paid for the majority of LTSS spending (70.8%). Medicaid and Medicare are, respectively, the first- and second-largest public payers, and in 2018 accounted for nearly two-thirds (64.6%) of all LTSS spending nationwide. Other public programs that finance LTSS for specific populations are a much smaller share of total LTSS funding (6.2%). These public sources include the Veterans Health Administration

(VHA) and Children’s Health Insurance Program (CHIP), among others. It is important to note that the eligibility requirements and benefits provided by these public programs vary widely. Moreover, among the various public sources of LTSS financing, none are designed to cover the full range of services and supports that may be desired by individuals with long-term care needs. Some Medicare spending is similar to Medicaid LTSS spending in that both payers cover stays in institutional settings, such as nursing homes, as well as visits by home health agencies, although the service type and scope of coverage differ.

In the absence of public funding for LTSS, individuals must rely upon private funding. In 2018, private sources accounted for 29.2% of LTSS expenditures. Within the category of funding, out-of-pocket spending was the largest component (over one-half of private sources), comprising 14.9% of total LTSS expenditures. Second was private insurance (8.2%), which includes both health and long-term care insurance. Other private funding, which largely includes philanthropic contributions, comprised 6.1% of total LTSS. The following provides a brief discussion of the various public and private sources of LTSS funding.

Figure 1. Long-Term Services and Supports (LTSS) Spending, by Payer, 2018
(in billions)



Source: CRS analysis of National Health Expenditure Account (NHEA) data obtained from the Centers for Medicare & Medicaid Services, Office of the Actuary, prepared December 2019.

Notes: This analysis of NHEA data also includes Medicare post-acute care spending in an expanded definition of LTSS spending.

Over the past 20 years, the share of public funding for LTSS has increased (from 62.8% in 1998 to 70.8% in 2018), largely due to an increase in the share of Medicaid LTSS funding. In addition, the share of private LTSS funding, primarily related to out-of-pocket spending, has decreased from 37.2% to 29.2% over the same 20-year time period.

Medicaid

Medicaid is a means-tested health and LTSS program funded jointly by federal and state governments. Medicaid funds are used to pay for a variety of health care services and LTSS, including nursing facility care, home health, personal care, and other home and community-based services. Each state designs and administers its own program within broad federal guidelines. Medicaid is the largest single payer of LTSS in the United States; in 2018, total Medicaid LTSS spending (combined federal and state) was \$180.5 billion, which comprised 44.1% of all LTSS expenditures. In 2018, Medicaid LTSS accounted for 33.9% of all Medicaid spending, which represented about 5.9% (4.2 million) of the enrolled population receiving LTSS in FY2013 (the most recent year for which data are available).

Medicare

Medicare is a federal program that pays for covered health services for the elderly and for certain non-elderly individuals with disabilities. Medicare covers primarily acute and post-acute care, including skilled nursing and home health services. Medicare-certified nursing homes are referred to as skilled nursing facilities (SNFs). Unlike Medicaid, Medicare is not intended to be a primary funding source for LTSS. These post-acute Medicare benefits provide limited access to personal care services both in the home care setting and in SNFs for certain beneficiaries. While Medicaid nursing and home health benefits are available to eligible beneficiaries for as long as they qualify, Medicare benefits are generally limited in duration. In addition, Medicare SNF and home health benefits include coverage of rehabilitation services that will, presumably, prevent a decline in the beneficiary's physical condition or functional status. In 2018, Medicare spent \$83.7 billion on SNF and home health services combined, which was about one-fifth (20.4%) of all LTSS spending, under the expanded definition. These expenditures include Medicare Parts A and B (also referred to as "Original Medicare") and estimated Medicare Part C (Medicare Advantage) payments attributable to SNF care and home health care. Of total Medicare LTSS spending, in 2018, 50.3%, or \$42.2 billion, was paid to home health agencies, and 49.6%, or \$41.5 billion, was paid to SNFs.

Other Public Payers

Of all LTSS expenditures in the United States, a relatively small portion of the costs are paid for with public funds other than Medicare or Medicaid. Collectively, these payers covered 6.2% of all LTSS expenditures in 2018, totaling \$25.6 billion. Among these public payers, over half of spending (\$14.5 billion, or 56.9%) was for LTSS provided in residential care facilities for individuals with intellectual and developmental disabilities, mental health conditions, and substance abuse issues. Spending in this category also includes LTSS paid for or operated by Veterans Health Administration (\$6.4 billion, or 25.0%). Another \$3.8 billion, or 14.9%, includes state and local subsidies to providers and temporary disability insurance. A smaller percentage was spent on general assistance, which includes expenditures for state programs modeled after Medicaid, as well as federal and state funding for nursing facilities and

home health under CHIP. In addition, some public LTSS spending includes two types of programs that capture federal health care funds and grants to various federal agencies and Pre-existing Conditions Insurance Plans. Collectively public spending from these sources totaled \$707 million, or 2.8%.

Out-of-Pocket Spending

Out-of-pocket spending was 14.9% of total LTSS spending, or \$61.1 billion, in 2018. Expenditures in this category include deductibles and copayments for services that are primarily paid for by another payment source as well as direct payments for LTSS. While there are daily copayments for skilled nursing services after a specified number of days under Medicare, there are no copayments for Medicare's home health services. In addition, some private health insurance plans provide limited skilled nursing and home health coverage, which may require copayments. Moreover, private long-term care insurance (LTCI) often has an elimination or waiting period for policyholders that requires out-of-pocket payments for services for a specified period of time before benefit payments begin. Once individuals have exhausted their Medicare and/or private insurance benefits, they must pay the full cost of care directly out-of-pocket. With respect to Medicaid LTSS, individuals must meet both financial and functional eligibility requirements. Individuals not initially eligible for Medicaid, and not covered under a private LTCI policy, must pay for LTSS directly out-of-pocket. Eventually, these individuals may spend down their income and assets and thus meet the financial requirements for Medicaid eligibility.

Private Insurance

Private health and long-term care insurance plays a much smaller role in financing LTSS; 8.2% of total LTSS spending, or \$33.4 billion, was funded through these sources. Private insurance expenditures for LTSS include both health and LTCI. Similar to Medicare LTSS funding, private health insurance funding for LTSS includes payments for some limited home health and skilled nursing services for the purposes of rehabilitation. Private LTCI, on the other hand, is purchased specifically for financial protection against the risk of the potentially high costs associated with LTSS. In addition, a number of hybrid products that combine LTCI with either an annuity or a life insurance policy have emerged. The Medicaid Long-Term Care Insurance Partnership Program offers a LTCI policy that is linked to Medicaid eligibility.

Other Private Funds

Other private funds generally include philanthropic support, which may be directly from individuals or obtained through philanthropic fund-raising organizations such as the United Way. Support may also be obtained from foundations or corporations. In 2018, other private funding accounted for 6.1% of total LTSS spending, or \$25.0 billion.

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