



## Who Pays for Long-Term Services and Supports?

Long-term services and supports (LTSS) refers to a broad range of health 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 U.S. population aged 65 and older continues to increase in size, and individuals continue to live longer post-retirement, the demand for LTSS is expected to increase. In addition, advances in medical and supportive care may allow younger persons with disabilities to live longer (see CRS In Focus IF10427, *Overview of Long-Term Services and Supports*).

CRS analyzed data from the Centers for Medicare & Medicaid Services (CMS) National Health Expenditure Accounts (NHEA) to examine personal health expenditures for LTSS by payer. This analysis includes Medicare post-acute care spending for home health and skilled nursing facility (SNF) care in an expanded definition of LTSS spending. This is due to NHEA data providing expenditures by care setting (e.g., home health, nursing home, residential care), which do not distinguish whether care provided in a given setting is for post-acute or LTSS. Using this definition, total U.S. spending on LTSS is a significant component of all personal health care spending. In 2020, an estimated \$475.1 billion was spent on LTSS, representing 14.1% of the \$3.4 trillion spent on personal health care.

NHEA data for LTSS expenditures include payments 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). However, the NHEA data underestimate the total costs of providing LTSS because they do not capture LTSS provided by family members, friends, and other uncompensated caregivers. This report provides information on spending among the primary LTSS payers.

### Who Pays for Long-Term Services and Supports?

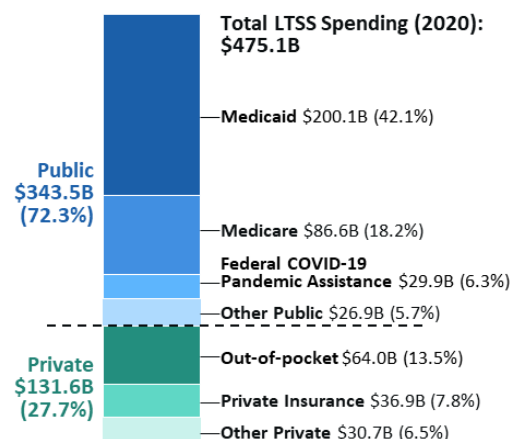
LTSS are financed by a variety of public and private sources. **Figure 1** shows LTSS spending by payer for 2020. Public sources paid for the majority of LTSS spending (72.3%). Medicaid and Medicare are, respectively, the first- and second-largest public payers, accounting for 60.4% (not shown) of all LTSS spending nationwide in 2020. In response to the pandemic, NHEA data included a new category of spending for federal COVID-19 pandemic assistance, which was 6.3% of total LTSS spending. In

addition, 2020 spending in other categories reflect the net effect of any changes in LTSS utilization and costs related to the pandemic, as well as relevant regulatory and statutory changes made during the COVID-19 public health emergency. LTSS spending for other public programs (e.g., Veterans Health Administration [VHA], Children’s Health Insurance Program [CHIP]) was 5.7% in 2020.

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 LTSS funding, individuals must rely upon private funding. In 2020, private sources accounted for 27.7% of LTSS spending. Out-of-pocket spending remained the largest component, at 13.5% of total LTSS spending. Second was private insurance (7.8%), which includes both health and long-term care insurance. Other private funding, which largely includes philanthropic contributions, comprised 6.5% of LTSS spending.

**Figure 1. Long-Term Services and Supports (LTSS) Spending, by Payer, 2020**  
(in billions)



**Source:** CRS analysis of National Health Expenditure Account (NHEA) data obtained from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, prepared December 2021.

**Notes:** Analysis includes Medicare post-acute care spending in an expanded definition of LTSS spending. Percentages may not sum to 100% due to rounding.

Over the past 20 years, the share of public LTSS spending has increased (from 64.3% in 2000 to 72.3% in 2020), primarily due to Medicare funding. For 2020, increased public LTSS spending reflects the new category of federal COVID-19 pandemic assistance and net effect of the pandemic in general. Over the same period, the share of private LTSS funding, primarily related to out-of-pocket spending, has decreased from 35.7% to 27.7%.

### 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 2020, total Medicaid LTSS spending (combined federal and state) was \$200.1 billion, which comprised 42.1% of all LTSS expenditures. In 2020, Medicaid LTSS accounted for 34.1% of all Medicaid personal health care spending, which represented about 5.4% (4.4 million) of the enrolled population who received Medicaid-covered LTSS in FY2019 (the most recent year for which data are available).

### Medicare

Medicare is a federal program that pays for covered health services for older adults (aged 65 and over) and for certain younger individuals with disabilities. Medicare covers primarily acute and post-acute care, including skilled nursing and home health services. 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 SNF 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 2020, Medicare spent \$86.6 billion on SNF and home health services combined, which was 18.2% of all LTSS spending, under the expanded definition. These expenditures include Medicare Parts A and B and estimated Medicare Advantage (Part C) payments attributable to SNF and home health care. Of total Medicare LTSS spending in 2020, half was paid for home health services and half was paid for SNF services (\$43.3 billion, respectively).

### Federal COVID-19 Pandemic Assistance

In 2020, for the first time, federal funding included COVID-19 pandemic assistance from the Paycheck Protection Program (PPP) Loans and the Provider Relief Fund, which enabled federally certified LTSS providers (e.g., home health agencies and nursing facilities) to cover expenses and recuperate lost revenue resulting from the pandemic. This assistance represented \$29.9 billion, or 6.3% of all LTSS expenditures in 2020.

### Other Public Payers

Of all LTSS expenditures in 2020, a relatively small portion of the costs are paid for with public funds other than Medicare or Medicaid. Collectively, these payers covered 5.7% of all LTSS expenditures in 2020, totaling \$26.9 billion. Of this total, \$15.1 billion, representing 56.3% of other public funding, 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 \$7.0 billion (26.1%) for LTSS paid for or operated by the VHA, \$4.0 billion (14.9%) for state and local subsidies to providers and temporary disability insurance, and \$747 million (2.8%) for state programs modeled after Medicaid and federal and state CHIP funding for nursing facilities and home health.

### Out-of-Pocket Spending

Out-of-pocket spending was 13.5% of total LTSS spending (\$64.0 billion) in 2020. 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. Under Medicare, there are daily copayments for SNFs after a specified number of days and no copayments for home health services. In addition, some private health insurance plans provide limited SNF and home health coverage, which may require copayments. Moreover, private long-term care insurance (LTCI) often has a 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. 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. Eventually, they may spend down their income and assets to meet the financial requirements for Medicaid eligibility.

### Private Insurance

Private health and long-term care insurance plays a much smaller role in financing LTSS; 7.8% of total LTSS spending (\$36.9 billion) was funded through these sources. 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, there are a number of hybrid products that combine LTCI with either an annuity or a life insurance policy. The Medicaid Long-Term Care Insurance Partnership Program offers a LTCI policy that is linked to Medicaid eligibility.

### Other Private Funds

Other private funds accounted for 6.5% of total LTSS Spending (\$30.7 billion) in 2020. These funds include philanthropic support through individuals or philanthropic fund-raising organizations, as well as support obtained from foundations or corporations.

**Kirsten J. Colello**, Specialist in Health and Aging Policy

---

## Disclaimer

This document was prepared by the Congressional Research Service (CRS). CRS serves as nonpartisan shared staff to congressional committees and Members of Congress. It operates solely at the behest of and under the direction of Congress. Information in a CRS Report should not be relied upon for purposes other than public understanding of information that has been provided by CRS to Members of Congress in connection with CRS's institutional role. CRS Reports, as a work of the United States Government, are not subject to copyright protection in the United States. Any CRS Report may be reproduced and distributed in its entirety without permission from CRS. However, as a CRS Report may include copyrighted images or material from a third party, you may need to obtain the permission of the copyright holder if you wish to copy or otherwise use copyrighted material.