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Who Pays for Long-Term Services and Supports? A Fact Sheet

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Long-term services and supports (LTSS) refer to a broad range of health and health-related services and supports 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 (e.g., eating, bathing, dressing, walking) or activities that allow individuals to live independently in the community (e.g., shopping, housework, meal preparation). The most recent published data estimating the number of Americans in need of LTSS indicate that about 10.9 million individuals living in the community need LTSS, or 4.1% of the community-resident population. It was estimated another 1.8 million individuals needing LTSS live in an institutional setting, such as a nursing home.[1]

Total U.S. spending on formal or paid LTSS is a significant component of all personal health care spending. In 2013, an estimated $338.8 billion was spent on LTSS, representing 13.7% of the $2.5 trillion spent on personal health expenditures.[2] Spending for LTSS includes payments for services in nursing facilities, and in residential care facilities for individuals with intellectual and developmental disabilities, mental health conditions, and substance abuse issues. Spending also includes LTSS provided in an individual's own home, such as home health, personal care, and homemaker or chore services (e.g., housework or meal preparation), as well as a wide range of home and community-based services (HCBS), including adult day health services. A substantial amount of LTSS is also provided by informal caregivers—family and friends—who provide care without compensation. As a result, spending on LTSS may be underestimated, as spending data do not include uncompensated care provided by informal caregivers. This report provides information on who the primary LTSS payers are and how much they spend.[3]

Who Pays for Long-Term Services and Supports?

Formal LTSS are paid by a variety of public and private sources. **Figure 1** shows LTSS spending by payer for 2013. Public sources account for the majority of LTSS spending (71.5%). Medicaid and Medicare are the first- and second-largest public payers, respectively, and accounted for nearly two-thirds (64.5%) of all LTSS spending nationwide in 2013. Other public programs that finance LTSS for specific populations provide a much smaller share of total LTSS funding (7.0%). These public sources of funding include the Veterans Health Administration (VHA) and Children's Health Insurance Program (CHIP), among others.[4] It is important to note that the eligibility requirements and benefits provided by these public programs vary widely. Moreover,

[1] H. S. Kaye, C. Harrington, and M. P. LaPlante, "Long-Term Care: Who Gets It, Who Provides It, Who Pays, And How Much?" *Health Affairs*, vol. 29, no. 1 (January 2010), p. 13.

[2] LTSS expenditure data are from the National Health Expenditure Accounts (NHEA) published annually by the U.S. Department of Health and Human Services (HHS). NHEA data represent aggregate health care spending. Data reported are for 2013 and are for personal health expenditures, which is a subcategory of national health expenditures, and excludes the following expenditure categories: government administration, net cost of health insurance, government public health activities, and investment. NHEA LTSS expenditure data analyzed in this report include the following expenditure categories: home health, nursing care facilities and continuing care retirement communities, and residential intellectual and developmental disability, mental health, and substance abuse facilities. Some LTSS expenditures are not captured in the NHEA, such as certain community or residential care facilities that primarily provide social assistance or services rather than health care.

[3] For a discussion of various approaches in estimating national LTSS spending, see Bipartisan Policy Center, *America's Long-Term Care Crisis: Challenges in Financing and Delivery*, April 2014, p. 26.

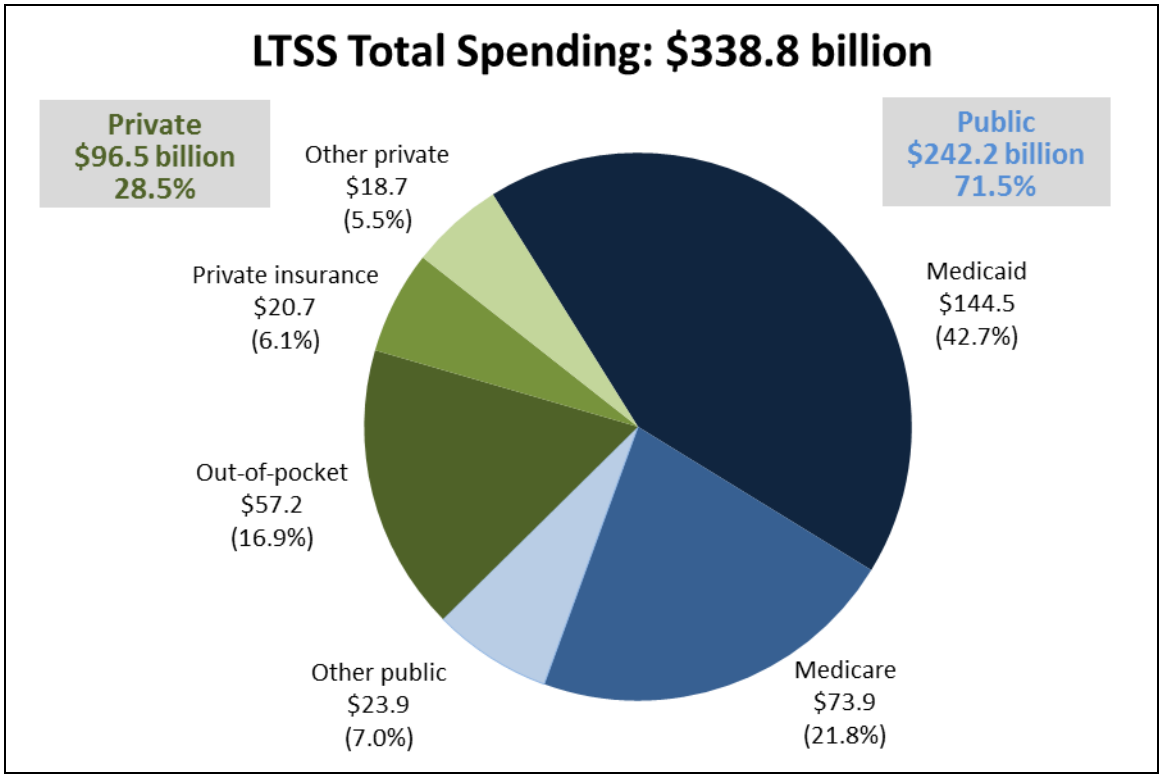
[4] LTSS expenditure data from the NHEA do not include federal funding provided under the Older Americans Act (OAA) or Title XX of the Social Security Act (SSA), the Social Services Block Grant Program (SSBG).

among the various public sources of LTSS financing, none is designed to cover the full range of services and supports that may be desired by individuals with long-term care needs.

In the absence of public funding for LTSS, individuals must rely on private sources of funding. In 2013, about 28.5% of LTSS expenditures were paid by private sources. Within private sources of funding, out-of-pocket spending was the largest component (over one-half of all private funding), comprising 16.9% of total LTSS expenditures. Second was private insurance (6.1%), which includes both health and long-term care insurance. Finally, other private sources, which largely include philanthropic contributions, comprised 5.5% 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, 2013

(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, 2014.

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 2013, total Medicaid spending (combined federal and state) was 42.7% of all LTSS expenditures at $144.5 billion. In 2013, Medicaid LTSS accounted for over one-third (35.2%) of all Medicaid spending despite the fact that LTSS recipients represent a relatively small share of the total Medicaid population. The

most recent data available estimated that 6.4% of Medicaid recipients (or 4.2 million beneficiaries) received LTSS in FY2010.[5]

Medicare

Medicare is a federal program that pays for covered health services for the elderly and certain non-elderly individuals with disabilities. Medicare covers primarily acute care benefits; however, it also provides some coverage for two types of LTSS: skilled nursing facility (SNF) services and home health services. However Medicare, unlike Medicaid, is not intended to be a primary funding source for LTSS. These Medicare benefits provide limited access to personal care services both in the home care setting and in skilled nursing facilities for certain beneficiaries on a short-term basis. While Medicaid SNF and home health benefits are available to eligible beneficiaries for as long as they qualify, Medicare's SNF and home health benefits, in general, are limited in their 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 2013, Medicare spent $73.9 billion on SNF and home health services combined, which was over one-fifth (21.8%) of all LTSS spending. 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.[6] Of total Medicare LTSS spending, 49.3%, or $36.4 billion, was paid to home health agencies, and 50.7%, or $37.5 billion, was paid to SNFs.

Other Public Payers

Of all LTSS expenditures in the United States, only a small portion of the costs are paid for with public funds other than Medicare or Medicaid. Collectively, these payers covered 7.0% of all LTSS expenditures in 2013, totaling $23.9 billion. Among these public payers, over half ($13.1 billion, or 54.9%) of spending 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 VHA ($5.6 billion, or 23.3%). Another $4.4 billion, or 18.5%, includes state and local subsidies to providers and temporary disability insurance. A smaller proportion 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 other federal spending on two types of programs that capture federal health care funds and grants budgeted to various federal agencies and Pre-existing Conditions Insurance Plans. Collectively public spending for these programs totaled $795 million, or 3.3%.

Out-of-Pocket Spending

Out-of-pocket spending was 16.9% of total LTSS spending, or $57.2 billion, in 2013. These expenditures 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

[5] Medicaid and CHIP Payment and Access Commission (MACPAC), *Report to Congress on Medicaid and CHIP*, June 13, 2014, pg. 40.

[6] "Original Medicare" home health expenditures include payments to home health agencies for hospice services.

copayments for Medicare's home health services. In addition, some private health insurance plans may provide limited skilled nursing and home health coverage, which may or may not 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. Furthermore, to be eligible for Medicaid LTSS, individuals must meet both financial and functional eligibility requirements. Individuals not initially eligible for Medicaid would have to pay for LTSS directly out-of-pocket. Eventually, these individuals may spend down their income and assets over a period of time and meet the financial criteria for Medicaid eligibility.

Private Insurance

Private health and long-term care insurance plays a much smaller role in financing LTSS. In 2013, 6.1% of total LTSS spending, or $20.7 billion, was funded through these sources. Private insurance expenditures for LTSS include both health and LTCI. Similar to Medicare funding for LTSS, 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 to provide financial protection against the risk of the potentially high costs associated with LTSS. Additionally, a number of hybrid products that combine LTCI with either an annuity or a life insurance product have recently emerged. Moreover, the Medicaid Long-Term Care Insurance Partnership Program is also a LTCI product 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 2013, 5.5% of total LTSS spending, or $18.7 billion, was funded through other private funds.

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