Paying for Family Caregiving in Long-Term Care Insurance

12% of Medicaid Long-Term Care Spending on Single Elderly with Adult Children (0.09% of Total Health Spending)

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Issue Summary: The elderly face significant risk of large, persistent long-term care (LTC) expenses. Yet the private LTC insurance market is remarkably small. In 2023, about $459 billion was spent on LTC in the U.S., with Medicaid paying roughly 60%. While about 70% of the elderly will need LTC at some point, fewer than 10% own a private LTC insurance policy. A central but overlooked reason is the family: because both private insurance and Medicaid reimburse formal care but almost never informal (family) care, households with a potential family caregiver face a trade-off between insuring formal care costs and relying on preferred—but uninsured—family care.

Policy Recommendation: Policymakers should encourage LTC insurers to offer benefits that can be taken as cash that can compensate for family care, not solely for formal services (i.e., in-kind benefits). Converting benefits from in-kind to cash could raise enrollment, make families better off, and reduce Medicaid spending. Where there is concern that people might claim benefits they do not truly need, cash benefits can be paired with a check on care need.

Potential Savings: An economic model finds that replacing in-kind private insurance benefits with cash benefits of equal value nearly triples enrollment from about 6% to 15% of single elderly with adult children. The policy also makes families better off by roughly $4,000 each on average—about $1,000 for the poorest two-fifths of families, rising to about $6,000 for wealthier ones. Because insured families are less likely to spend down their savings to qualify for Medicaid, cash benefit insurance would reduce Medicaid LTC spending for this group by about 12% and slightly lower their Medicaid participation from about 20% to 19%. Savings accrue to the federal government and state Medicaid budgets. Estimates apply only to single elderly with adult children (about 40% of those 65 and over) and could shrink if the cost of verifying care need raises premiums.

Related Literature and Evidence:

Mommaerts, Corina. 2025. "Long-Term Care Insurance and the Family." *Journal of Political Economy* 133(1).

Background

The elderly face significant risk of large, persistent long-term care (LTC) expenses. The U.S. spent $459 billion on LTC in 2023—roughly 10% of all U.S. health spending and projected to rise sharply with population aging (Rudowitz et al. 2025). While 70% of the elderly will rely on some form of LTC, the distribution is highly skewed (Johnson 2019). About half of those who need care will need it for less than a year, but 14% of women and 6% of men will need five or more years of paid care, at an average lifetime cost exceeding $665,000 (Giese et al. 2026).

Despite this risk, the private LTC insurance market is small. Fewer than 10% of the elderly own a private policy (Mommaerts 2025). People typically purchase policies in their 50s and 60s, but applicants are frequently rejected; even when accepted, their coverage rarely offers lifetime benefits (AALTCI 2024). Policies pay out about 18% less in expected benefits than in premium contributions (Brown and Finkelstein 2008).

Public LTC coverage comes almost entirely from Medicaid, which finances roughly 60% of formal LTC (Rudowitz et al. 2025). However, people must have low income and few assets to qualify. For LTC, most states cap monthly income at 300% of the federal SSI benefit ($2,982 per month per person in 2026) and limit assets to $2,000 per person, a threshold unchanged since 1989 (Burns et al. 2026). Because these limits are so low, many people qualify only after depleting their savings on care.

Crucially, more than half of LTC is provided informally by family members—predominantly spouses and adult children. Yet neither private insurance nor Medicaid meaningfully reimburses informal care. In the rare cases in which private insurance offers informal care benefits, the benefits are small and limited by many exclusions and caps; for example, one LTC insurer paid up to about $30 per day, capped at near $900 per year, versus roughly $36,000 per year of nursing facility coverage (Genworth 2019). Medicaid coverage of family care is also limited and often waitlisted. The indirect costs of informal care—chiefly caregivers' lost wages—are large; one estimate places them at about $520 billion per year (Chari et al. 2015), on top of the formal LTC bill.

This creates a market gap. The expectation of family care can make skipping insurance a sensible choice for many families (Pauly 1990). Because insurers cannot tell which buyers have a family caregiver to fall back on, the people who buy coverage are disproportionately those most likely to need paid care — pushing premiums up and shrinking the market (Ko 2022). Because insurance covers formal care but not family care, households with a potential caregiver must weigh insuring formal care costs against relying on preferred family care whose costs go uninsured. Single retirees with children are about 5 percentage points less likely to own LTC insurance than those without children—an effect concentrated among wealthier households and not explained by differences in health or general insurance-buying (Mommaerts 2025). Whether the availability of family care holds insurance below its ideal level, and how alternative policies would perform, has not been quantified.

Evidence Base

My study (Mommaerts 2025) builds and estimates an economic model of LTC decisions between an elderly parent and her adult child, using data from the Health and Retirement Study (HRS) and the Panel Study of Income Dynamics (PSID). In the model, the family faces unpredictable LTC needs, uncertainty about how long the parent will live, and swings in the child's wages; the parent and child cooperate only as far as it benefits each of them, since neither can make binding promises about the future. The model reproduces observed insurance purchases, savings, use of family care, how much adult children work, and Medicaid enrollment across the wealth distribution. The model is then used to simulate what would happen if the availability of family care or the form of insurance benefits changed. All results pertain to single elderly with adult children, who make up about 40% of those 65 and over. Key findings include:

The availability of family care substantially lowers demand for LTC insurance. Removing the availability of family care raises insurance demand by 7 percentage points overall (from 5.9% to 13.4%) among single parents with adult children. The effect is concentrated in the upper 60% of the wealth distribution: while there is practically no effect among the poorest parents, the wealthier parents' demand for LTC insurance increases by 17 percentage points. This suggests that wealthy families place a high value on protecting assets, while less well-off families largely rely on Medicaid instead of buying private coverage.

The quality of LTC coverage affects demand. Even when individuals lack family care, few buy coverage unless the insurance is made complete and priced fairly. This reflects well-documented flaws in existing LTC insurance contracts, like incomplete coverage, high markups, and frequent rejections.

Converting benefits from in-kind (formal care) to cash raises enrollment and makes families better off. A private policy paying cash of equal value—usable to compensate family care—nearly triples the share who buy coverage, to about 15% (roughly 10–20% across the wealth distribution). Even poorer families buy it rather than deplete their savings to fall back on Medicaid, and families are better off by about $4,000 each on average (about $1,000 for the poorest two-fifths of families and up to about $6,000 for wealthier ones).

Cash benefits raise a concern that people could claim payments without truly needing care, so a check (evaluations, home visits) may be required. Even after raising premiums by 50% to fund those checks, demand for cash-benefit insurance stays at least as high as for insurance that only reimburses formal care, though the gains to families shrink and turn negative for the wealthiest. Converting Medicaid's own benefit to cash, by contrast, barely changes private insurance demand, since more well-off individuals still value protecting assets and the less well-off are already enrolled.

Family care—and whether insurance covers it—significantly affects Medicaid enrollment and spending. Losing access to family care would push many families onto Medicaid, sharply raising both enrollment and LTC spending, while cash-benefit insurance would pull modestly in the other direction. For the single elderly with adult children, removing the availability of family care raises their Medicaid participation from about 20% to 28% (nearly a 50% increase) and roughly doubles total Medicaid LTC spending, as families spend down in lieu of insuring. This implies that demographic trends—lower fertility rates and higher female labor force participation—could sharply raise Medicaid LTC costs. Conversely, cash-benefit private insurance modestly lowers Medicaid participation and cuts this group's Medicaid LTC spending by about 12% (to roughly 88% of the benchmark), because insured families are less likely to impoverish themselves to qualify for the program.

Policy Recommendation

Policymakers should encourage LTC insurance benefits to be paid as cash that compensates family care, rather than solely as reimbursement for formal services. Because in-kind, formal-care-only benefits are a significant reason households decline coverage, adding a cash option would align the product with the care families prefer and use.

Policymakers could encourage insurers to offer cash-benefit riders or policies. Because LTC insurance is notoriously hard to price over long time horizons, regulators could support demonstration pilots, standardized contract terms, and backstops (reinsurance) to manage risk.

The policy design should weigh a core trade-off: cash benefits better match family preferences and leave them better off, but they require verification to ensure benefits are targeted to those who need it. Oversight through periodic evaluations or home visits could accomplish this, but they add to administrative costs. Evidence from other countries with cash-for-care LTC systems, and from U.S. Medicaid Cash and Counseling pilots, can guide implementation.

Potential Savings

Per the study's economic model, replacing in-kind private insurance benefits with cash benefits of equal value raises enrollment from about 6% to 15%. Because insured families are less likely to spend down to qualify for Medicaid, this reduces Medicaid LTC spending for the group by about 12% (to roughly 88% of the benchmark) and slightly lowers Medicaid participation (from about 20% to 19%). Families are better off by roughly $4,000 each, on average. The model notes partially offsetting fiscal effects, such as a modest decline in income tax revenue as some adult children provide more care and work less.

To caveat, the estimates apply only to single elderly with adult children. They may not generalize to couples, where a spouse who provides care often gives up less income than an adult child would. Gains from cash benefits shrink if premiums must rise to fund checks on care need; at higher markups, these gains fall and can turn negative for the wealthiest households. The results come from a structural model rather than a direct policy experiment, so they depend on the model's assumptions and its sample of single parents with adult children.

Public data published by CMS and ASPE allow for a rough, conservative savings estimate from converting the in-kind benefit to a cash benefit. In 2022, Medicaid LTSS spending (spanning HCBS and institutional care) on adults 65 and older totaled $84.4 billion (Wysocki et al. 2024). Roughly 40% of older adults with LTSS needs are single with children, consistent with the proportion seen in the HRS from 1998 to 2014 (Spillman et al. 2021, Table 1 in Mommaerts 2025). 40% of the LTSS spending figure is $33.8 billion. While this applies a headcount share to a spending figure—and thus is an unweighted estimate—this number arguably serves as a conservative floor. ASPE's 40% figure represents all payers; however, among older adults with LTSS needs, those who are single with children are over twice as likely to be on Medicaid than those who are married with children (Table 2, Spillman et al. 2021). Moreover, unmarried older adults use a third more formal services than married older adults (Favreault and Dey 2016). Assuming the model's 12% reduction in Medicaid spending for this population, this policy could save Medicaid roughly $4.05 billion in 2022 dollars, or 0.09% of total health spending that year.

Existing Policy Proposals

The Affordable Care Act of 2010 included the Community Living Assistance Services and Supports (CLASS) Act, a voluntary public LTC insurance program that would have included daily cash benefits that people could use to pay for home care (Kenen 2011). However, the program was deemed financially unworkable by the administration in 2011 and ultimately repealed by Congress.

The U.S. has experimented with cash-for-care on a limited basis. Several states piloted Medicaid "Cash and Counseling" demonstrations, which give beneficiaries a cash-like budget to purchase home-based services—and, in some cases, to pay family caregivers. Evidence from these pilots shows that cash-like benefits sharply reduce reliance on formal care (Lieber and Lockwood 2019). Most states now operate self-directed Home- and Community-Based Services (HCBS) programs, some of which already allow participants to hire family caregivers (Burns et al. 2026). States retain discretion over which relatives may be paid and how large the budget is, making these programs a natural vehicle for expanding compensation of family care.

At the federal level, Medicare is testing ways to directly support family caregivers. In July 2024, CMS launched the Guiding an Improved Dementia Experience (GUIDE) Model, a voluntary nationwide model

running through 2032 that pays providers to deliver comprehensive care for people with dementia and support their caregivers, with the goal of delaying nursing home placement (CMS 2026). GUIDE offers in-kind caregiver support and respite services rather than cash benefits paid to family members, but it reflects growing federal interest in defraying the costs of informal care. CMS has not published a savings estimate, but it expects the model to reduce both Medicare and Medicaid spending, primarily by preventing or delaying long-term nursing home stays. An independent evaluation is underway.

Many other countries—such as Austria, France, Germany, Italy, the Netherlands, and Sweden—operate LTC systems with cash options, providing models the U.S. could study (Da Roit and Le Bihan 2010).

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