



CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

August 21, 2002

S. 321

Family Opportunity Act of 2002

As ordered reported by the Senate Committee on Finance on July 11, 2002

SUMMARY

S. 321 would expand eligibility and benefits for disabled children under the Medicaid program. The bill would give states the option of providing coverage to certain children who meet the disability standard used in the Supplemental Security Income (SSI) program but are ineligible for SSI because they do not meet that program's income or asset requirements. The bill would also allow states to provide home and community-based services to individuals under age 21 who need inpatient psychiatric hospital services, and would extend eligibility to SSI recipients under age 21 during the month that they apply for SSI benefits.

In addition, the bill would appropriate \$12 million in funding over the 2003-2005 period for health information centers for families with disabled children, and would authorize the appropriation of an additional \$10 million for those centers for fiscal years 2006 and 2007.

In total, CBO estimates that enacting S. 321 would increase mandatory spending (primarily for expanded Medicaid assistance) by \$37 million in 2003 and by \$5.8 billion over the 2003-2012 period. Because the bill would affect direct spending, pay-as-you-go procedures would apply. CBO also estimates that appropriation of the authorized amounts for the health information centers would cost \$10 million over the 2006-2010 period.

The bill contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). CBO estimates that total state spending for Medicaid would increase by \$4.9 billion over the 2003-2012 period, and that state spending for the State Children's Health Insurance Program (SCHIP) would decrease by \$280 million over the same period.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of S. 321 is shown in the following table. The costs of this legislation fall within budget function 550 (health).

	By Fiscal Year, in Millions of Dollars										2003- 2012
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	
CHANGES IN DIRECT SPENDING											
Medicaid Coverage for Disabled Children											
Medicaid											
Estimated Budget Authority	0	0	90	260	480	670	790	830	890	950	4,960
Estimated Outlays	0	0	90	260	480	670	790	830	890	950	4,960
State Children's Health Insurance Program											
Budget Authority	0	0	0	0	0	0	0	0	0	0	0
Estimated Outlays	0	0	-30	-95	-165	-200	120	-95	-95	-100	-660
Medicaid Interaction with SCHIP											
Estimated Budget Authority	0	0	-10	-35	-65	-85	-250	-140	-140	-145	-870
Estimated Outlays	0	0	-10	-35	-65	-85	-250	-140	-140	-145	-870
Medicaid Home and Community-Based Services											
Estimated Budget Authority	20	70	130	175	200	230	265	300	345	390	2,125
Estimated Outlays	20	70	130	175	200	230	265	300	345	390	2,125
Medicaid Eligibility for Certain SSI Recipients											
Estimated Budget Authority	15	20	20	20	25	25	30	30	35	35	255
Estimated Outlays	15	20	20	20	25	25	30	30	35	35	255
Health Information Centers											
Budget Authority	3	4	5	0	0	0	0	0	0	0	12
Estimated Outlays	2	3	4	2	a	a	0	0	0	0	12
Total Changes in Direct Spending											
Estimated Budget Authority	38	94	235	420	640	840	835	1,020	1,130	1,230	6,482
Estimated Outlays	37	93	204	327	475	640	955	925	1,035	1,130	5,822
CHANGES IN SPENDING SUBJECT TO APPROPRIATION											
Health Information Centers											
Authorization Level	0	0	0	5	5	0	0	0	0	0	10
Estimated Outlays	0	0	0	3	5	2	a	a	0	0	10

NOTE: Components may not sum to totals because of rounding.

a = less than \$500,000

BASIS OF ESTIMATE

Enacting S. 321 would have significant effects on direct spending over the next 10 years, as well as a small effect on discretionary spending beginning in 2006.

Direct Spending

CBO estimates that S. 321 would increase direct spending by a total of \$5.8 billion over the 2003-2012 period. Those costs would be due primarily to expanded Medicaid coverage of disabled children and the increased use of Medicaid home and community-based services.

Medicaid Coverage for Certain Disabled Children. Section 2 of the bill would allow state Medicaid programs to cover individuals under age 18 who meet the disability standard used for children in the SSI program but do not meet that program's income or asset restrictions. Eligibility would be limited to children with family income below a specified amount, set by each state, that could not exceed 250 percent of the federal poverty level. The parents of those children would be required to purchase private health insurance through their employer if the employer offers family coverage and subsidizes at least 50 percent of the cost of premiums. States would also be able to impose premiums on a sliding scale for the Medicaid coverage. This provision would take effect on October 1, 2004.

CBO estimates that this provision would lead to a net increase in direct spending of \$3.4 billion over the 2005-2012 period. Additional Medicaid spending for disabled children would cost \$5.0 billion over that period, but those costs would be offset by savings of \$0.7 billion in SCHIP and \$0.9 billion in Medicaid because of interactions between Medicaid and SCHIP. The provision's effects are discussed in greater detail below.

Number of disabled children. CBO relied on data from the National Health Interview Survey (NHIS) on the number of people with disabilities in 1994 and population projections from the Social Security Administration to estimate the number of children that have a disability that meets the SSI standard. We made several adjustments to the number of children that the NHIS estimated had a "specific, chronic, and life-limiting" disability—the most severe definition used in the survey. We accounted for underreporting (the NHIS did not assess all forms of disability) and excluded 18-year-olds, who would not be eligible under the bill.

The SSI disability standard for children is quite stringent, requiring a child to have a medically determinable condition that results in "marked and severe functional limitations" and will either last at least 12 months or result in death. For this reason, CBO assumed that only 90 percent of those children would qualify as disabled under the bill. After those

adjustments, CBO estimated that 2.6 million children—about 3.4 percent of U.S. children—would meet the SSI disability standard in fiscal year 2005, the year that the provision would take effect.

CBO anticipates that about 1.6 million of those children would be receiving Medicaid under current law, either as SSI recipients (who are automatically eligible for Medicaid in most states) or under other eligibility categories. The remaining 1 million children, who have a disability that meets the SSI standard but are not enrolled in Medicaid, form the starting point in estimating the number of new Medicaid recipients under the bill. We estimate that the number of children in this category would gradually decline to about 900,000 by 2012, mainly because of continued growth in the number of SSI recipients.

Number of new enrollees. CBO classified the disabled children not enrolled in Medicaid by family income and health insurance status using research from the NHIS, the General Accounting Office, the Economic and Social Research Institute, and other sources. (We estimate that about half of those children have family incomes below 250 percent of the poverty level and a majority of them have private health insurance.) We then estimated the additional Medicaid enrollment under the bill by making assumptions about the eligibility limits that participating states would set and the premium amounts that they would charge.

CBO anticipates that most of the states that expand Medicaid coverage under the bill would set their eligibility limits around 200 percent of the poverty level and that only a minority of participating states would set their limits above that level. We also expect that states would require the new enrollees to pay premiums on a sliding scale, as allowed under the bill. We assume that the premiums charged would range from zero for families with incomes below the poverty level to 2.5 percent of income for families with income equal to 250 percent of the poverty level.

CBO estimated the number of children that would enroll under the bill based on research from several sources on participation rates in SCHIP, where premiums are commonly charged. (Medicaid generally does not allow states to charge premiums.) We assumed that the participation rate under the bill would be on the high end of rates found in the studies. Families with disabled children are less likely than SCHIP families to view premiums as a deterrent because disabled children frequently have high medical expenses.

Overall, CBO estimates that Medicaid enrollment in 2005 would increase by about 100,000 children on a full-year equivalent basis, if all states decided to provide coverage under the bill. (Projected state participation is discussed below.) After 2008, the additional enrollment would range between 155,000 to 165,000 annually.

Based on research on health insurance coverage, we estimate that most of the additional enrollees—about 65 percent—would also have private health insurance from an employer

that pays at least 50 percent of the cost of premiums. Another 15 percent otherwise would have private health insurance from an employer that pays less than 50 percent of the cost of premiums; CBO assumes that this group would substitute coverage under the bill for family coverage. The remaining 20 percent would be uninsured.

Effect on the medically needy. In addition to new enrollees, the bill would also affect some children who receive Medicaid under current law through what is known as a "medically needy" program. Thirty-five states currently have medically needy programs that allow individuals to receive Medicaid after first spending a specified portion of their income on medical expenses. CBO anticipates that some of those states also would cover disabled children under the bill. In those states, some children who now receive Medicaid through a medically needy program would be able to qualify under the new eligibility category for disabled children. Medicaid spending for those children would increase because the program would now provide benefits without first requiring the children's families to pay some costs themselves.

CBO estimates that about 3,000 medically needy children in 2005 would qualify under the new eligibility category for disabled children. This figure would rise to about 19,000 in later years. Those estimates are based on enrollment data from the Centers for Medicare & Medicaid Services (CMS) and reflect CBO's assumptions about the number of states that would provide Medicaid coverage under the bill.

Per capita costs. CBO used two sets of per capita costs for newly enrolled disabled children—one for children with Medicaid only and another for those with both Medicaid and private health insurance. We estimate that the federal costs per full-year equivalent for children with Medicaid only would be about \$6,700 in 2005, rising to \$11,500 in 2012. For children with private health insurance, the Medicaid costs would be about \$3,500 in 2005 and increase to \$6,100 in 2012. Costs for children with private health coverage would be lower than for children with Medicaid only because private insurance would cover some costs that Medicaid would otherwise pay. Those estimates are based on Medicaid spending data from CMS and research on the value of private health insurance under the Federal Employees Health Benefits Program.

As noted above, the bill also would increase Medicaid spending for some children who currently qualify through medically needy programs. CBO estimates that the additional federal spending for those children would be about \$1,100 in 2005 and rise to \$1,800 by 2012.

State participation. CBO anticipates that under the bill states with about 10 percent of potential Medicaid costs would choose to cover disabled children in 2005. We expect that proportion to reach two-thirds by 2008 and remain at that level in subsequent years.

CBO believes that state participation eventually would be relatively high because the bill would give states another way to pay for services for children who are covered by the Individuals with Disabilities Education Act (IDEA), which requires states to provide special education services to all eligible students. States pay most of the costs of IDEA; federal funding for the program is subject to appropriation and represents less than 20 percent of the program's total cost. Because the bill expands Medicaid to more disabled children, states would be able to use Medicaid to pay for some of the services, such as transportation and physical therapy, that states currently provide to IDEA-eligible students. Medicaid would be an attractive funding source because the federal government pays at least 50 percent of the program's total cost and funding for the program is open-ended (i.e., it is not limited by appropriation or any other programmatic cap).

Premiums. The bill would allow states to charge premiums set on a sliding scale for Medicaid coverage for the newly eligible disabled children. Those premiums could not exceed 5 percent of family income and would be reduced to account for any premiums that families would be required to pay for private health insurance. CBO assumes that states would impose premiums only on families with incomes above the federal poverty level, and that the maximum premium would be 2.5 percent of income for families with income equal to 250 percent of the federal poverty level. (Using current poverty guidelines, the maximum premium would be about \$100 per month for a family of four.)

CBO estimates that the federal share of premium receipts would be about \$2 million in 2005 and would rise to \$22 million by 2012. Those receipts would offset only a small portion of the bill's costs because premiums would be based on family income rather than actual costs, which would be high for the children covered under the bill. The share of costs offset by the premiums also would decline over time because family income is expected to grow more slowly than the costs of medical care.

Additional administrative costs. CBO estimates that the bill would increase spending on Medicaid administrative costs by about \$45 million in 2005, rising to \$105 million by 2012. We anticipate that about 25 percent of those costs would be for eligibility determinations, claims processing, and collection of premiums. We assume that costs for eligibility determinations would be similar to those for disabled SSI applicants. The remainder would be administrative costs for disabled children that are currently paid by local school systems.

Effect on SCHIP. CBO anticipates that some of the disabled children who would receive Medicaid under the bill would be enrolled in SCHIP under current law. Because children who are eligible for Medicaid cannot receive SCHIP, the bill would lead to savings in SCHIP.

CBO estimates that about 10,000 children would lose their SCHIP eligibility in 2005 under the bill. That figure would rise to about 55,000 children by 2008, before declining to about 40,000 by 2012. Those figures are based on the NHIS disability survey and account for state participation. The number of affected children would decline in later years because CBO's baseline projections assume that annual SCHIP funding will remain constant after 2007. (Unlike Medicaid, which is an open-ended entitlement program, annual funding levels for SCHIP are set at specific amounts.) Since we expect the cost of medical care to continue growing in those years, we assume that one of the ways that states will respond will be to trim enrollment.

CBO varied the per capita savings for those children by type of SCHIP program. (A state can administer its SCHIP program either as an expansion of its Medicaid program or as a completely separate program.) Federal savings per capita in states with Medicaid expansions, which provide the comprehensive Medicaid package of benefits, would rise from \$8,200 in 2005 to \$14,100 in 2012. For states with separate programs, which provide less generous benefits, the corresponding savings would be \$3,900 in 2005 and \$6,600 in 2012. CBO assumes that 70 percent of affected children would come from states that administer their SCHIP programs separately from Medicaid.

Based on those assumptions, CBO estimates that moving SCHIP disabled children to Medicaid would reduce SCHIP spending by \$2.3 billion over the 2003-2012 period. However, states would use some of those savings to cover other children under SCHIP, particularly in later years as constraints on spending grow tighter. On net, estimated savings would be \$660 million over the 10-year period.

Medicaid interaction with SCHIP. Under current law, CBO expects that states will adopt a variety of measures to respond to the limited availability of SCHIP funds. One response—trimming enrollment—has already been discussed. Under that approach, some children who lose SCHIP would be picked up by the Medicaid program. We also anticipate that states will react by expanding Medicaid eligibility and shifting some children from SCHIP to Medicaid. That approach would enable states to continue receiving federal matching funds (albeit at a less-favorable match rate) and avoid cutting enrollment.

Since S. 321 would free up SCHIP funds to cover more nondisabled children, states would not need to rely on Medicaid to cover those children. As a result, CBO estimates that this effect would lead to savings in Medicaid totaling \$870 million over the 2003-2012 period.

Medicaid Home and Community-Based Services. Under Medicaid, states can establish programs—known as 1915(c) waiver programs after the section of the Social Security Act that authorizes them—that provide coverage for home and community-based services for individuals who otherwise would need services in a institution. Current law limits eligibility

for 1915(c) waiver programs to individuals who otherwise would need services in a hospital, nursing home, or intermediate care facility for the mentally retarded. Section 3 of the bill would allow 1915(c) waiver programs to cover individuals under age 21 who would otherwise need services in an inpatient psychiatric hospital. This provision would take effect on January 1, 2003.

CBO estimates that this provision would increase net federal spending on Medicaid by \$20 million in 2003 and by \$2.1 billion over the 2003-2012 period. Spending on home and community-based services would increase by about \$3.3 billion over that period, and be offset by \$1.1 billion in savings on spending for institutional services.

Spending on home and community-based services. CBO assumes that this provision would affect the same population as section 2 of the bill—children who have a disability that meets the SSI standard but are not enrolled in Medicaid. Based on research by the General Accounting Office, CBO assumes that about 25 percent of those children have a mental disorder. We increased the number of disabled children with mental disorders to account for those between the ages of 18 and 20, who are ineligible under section 2. After those adjustments, CBO anticipates that the number of children potentially affected by the bill would be about 315,000 in 2003 and would decline to about 280,000 by 2012.

CBO anticipates that this provision would increase enrollment in 1915(c) waiver programs by about 2,300 children in 2003, rising to 16,900 by 2012. About 80 percent of those children would be new Medicaid enrollees; the remainder would be existing enrollees that now receive institutional services. The new enrollees would ultimately be about 5 percent of the eligible population. Based on CMS data for current enrollees in 1915(c) waivers, CBO estimates that the per capita costs for those children would be about \$15,000 in 2003 and would rise to \$33,800 by 2012.

The additional spending for those children would represent only a modest increase in spending on 1915(c) waiver programs. The waivers are commonly used in Medicaid, partly because states can limit total enrollment in the programs. Based on data from CMS, we estimate that the number of people enrolled in 1915(c) waiver programs under current law will increase from about 650,000 in 2003 to about 800,000 by 2012. During the same period, federal spending on those waivers will jump from \$10.2 billion to \$28.5 billion. S. 321 would thus raise both the number of enrollees and spending in 1915(c) waiver programs by about 2 percent.

Spending on institutional services. Using data from CMS, CBO estimates that under current law Medicaid covers about 50,000 children annually in inpatient psychiatric hospitals. Under the bill, some of those children would be able to receive services in the community instead of in an institution. Services in an institution are extremely expensive, so the shift to home and community-based services for those children would reduce Medicaid spending.

As noted earlier, CBO estimates that about 20 percent of the new enrollees in 1915(c) waivers under the bill would be children that previously received institutional services. Drawing on CMS data, we estimate that per capita savings for those children would rise from about \$63,000 in 2003 to \$106,000 in 2012. However, we anticipate that only 50 percent of those savings would be realized because some of the newly available capacity in psychiatric institutions would be used to serve additional Medicaid enrollees.

Medicaid Eligibility for Certain SSI Recipients. Before the enactment of welfare reform in 1996, applications for SSI benefits were considered effective on the day that they were submitted. The welfare reform law changed the effective date of SSI applications to the first day of the following month and delayed when applicants become eligible for SSI. Since most SSI recipients are automatically eligible for Medicaid, the provision also delayed the effective date of Medicaid eligibility for new SSI recipients.

Section 5 of S. 321 would restore Medicaid eligibility for SSI recipients under age 21 between the day they apply for benefits and the first day of the following month. CBO estimates that this provision would increase federal Medicaid spending by \$15 million in 2003 and \$255 million over the 2003-2012 period.

This provision would be effective in the first calendar quarter beginning after the bill's enactment; CBO assumes that S. 321 would be enacted by the end of the calendar year and that the effective date would be January 1, 2003. We estimate that about 185,000 people under age 21 would become eligible for SSI in 2003, rising to about 200,000 by 2012. However, we anticipate that only about a third of those individuals would be affected by the bill. The remainder would be able under current law to offset the effects of the welfare reform law by using other eligibility categories to receive Medicaid between the day they apply for SSI benefits and the first day of the following month.

CBO assumes that the individuals affected by this provision would receive an additional two weeks of Medicaid benefits, on average. Based on Medicaid spending for disabled recipients, we estimate that the federal cost per capita of those additional benefits would be about \$280 in 2003 and increase to about \$550 in 2012.

Health Information Centers. Section 4 would require the Secretary of Health and Human Services to establish health information centers that provide various types of assistance to families with disabled children. Those services would include providing information on available health care resources and identifying successful ways to provide health care to disabled children. The centers would be part of the Maternal and Child Health grant program administered by the Health Resources and Services Administration.

The bill would fund the health information centers by appropriating \$3 million in 2003, \$4 million in 2004, and \$5 million in 2005. CBO estimates that outlays from that funding would be \$2 million in 2003 and a total of \$12 million over the 2003-2008 period. Our estimate is based on historical spending patterns in the Maternal and Child Health grant program.

Spending Subject to Appropriation

The bill would make funding for the health information centers subject to appropriation in 2006 and 2007, and would authorize the appropriation of \$5 million in each of those years. Assuming appropriation of the authorized amounts, CBO estimates that this provision would cost \$10 million over the 2006-2010 period.

PAY-AS-YOU-GO CONSIDERATIONS

The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays that are subject to pay-as-you-go procedures are shown in the following table. For the purposes of enforcing pay-as-you-go procedures, only the effects through fiscal year 2006 are counted.

	By Fiscal Year, in Millions of Dollars											
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	
Changes in outlays		0	37	93	204	327	485	640	955	935	1,035	1,140
Changes in receipts												Not applicable

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

The bill contains no intergovernmental or private-sector mandates as defined in UMRA. CBO estimates that, assuming states take advantage of the options provided in the bill, total state spending for Medicaid would increase by \$4.9 billion over the 2003-2012 period, and that state spending for SCHIP would decrease by \$280 million over the same period.

ESTIMATE PREPARED BY:

Federal Costs: Eric Rollins and Jeanne De Sa
Impact on State, Local, and Tribal Governments: Leo Lex
Impact on the Private Sector: Stuart Hagen

ESTIMATE APPROVED BY:

Peter H. Fontaine
Deputy Assistant Director for Budget Analysis