November, 2006

CATALYST CENTER
IMPROVING FINANCING OF CARE for Children & Youth WITH SPECIAL HEALTH CARE NEEDS

Methodology for Estimating the Impact of State Implementation of the Family Opportunity Act

Passed as part of the Deficit Reduction Act of 2005, the Family Opportunity Act (FOA) allows states the option of extending income eligibility and creating a buy-in program to expand Medicaid coverage to children with severe disabilities who have family incomes up to 300% of the Federal Poverty Level (FPL).

The Catalyst Center has developed a methodology for estimating the impact of state implementation of the FOA. **Please note: our methodology bases its estimates on national survey and administrative data. As a result, the estimates are not customized according to state-specific criteria such as SCHIP and Medicaid benefit comparability and family income eligibility for SCHIP.**[1] We suggest using the estimates generated by this model as an initial estimate of the impact of the FOA, and encourage interested parties to contact us to discuss strategies for refining the estimates using state-specific data.

Basic Assumptions

In order to estimate the number of children who will enroll in Medicaid under the FOA, we begin by making an assumption regarding the fraction of CSHCN[2] between 100% and 300% of FPL who are functionally eligible for Medicaid. We assume it is roughly similar but not exactly the same as the fraction of CSHCN below 100% of FPL who are functionally eligible for Supplemental Security Income (SSI). Under this assumption, it makes sense to think that the fraction of CSHCN between 100% and 300% of FPL who enroll in Medicaid will be slightly smaller than the fraction of children under 100% of FPL who are currently enrolled in SSI. We say 'slightly smaller than' rather than 'equal to' because we assume that:

- Families above 100% of FPL may be less aware, at least initially, of the new option of Medicaid coverage under the FOA than families whose children are eligible for SSI;
- The potential stigma associated by some with Medicaid coverage may discourage enrollment of families above 100% of FPL; and,

Boston University School of Public Health • Health and Disability Working Group
715 Albany Street, Boston, MA 02118 • Tel: 617-638-1930 • Fax: 617-638-1931 • http://www.hdwg.org/catalyst/index.php

- States will impose a modest premium requirement under the FOA. This may discourage enrollment among the uninsured who cannot afford the premiums and among privately insured families whose out-of-pocket costs do not exceed the cost of the premiums.

Approach and Additional Assumptions

Our approach is described in detail below, including the additional assumptions we have made in developing our estimates.

1. We use the 2001 National Survey of Children with Special Health Care Needs (NSCSHCN), conducted by the National Center for Health Statistics, as our basic data source.[3] This survey provides the most recent data available on a large national probability sample of children, with information on the number of CSHCN, the number of children receiving SSI benefits and type of coverage (public, private or uninsured).

2. As shown in **Table 1:** among CSHCN in families with incomes below 100% of FPL, SSI enrollment in 2001 was 28% for those without private insurance, and 18% for those with private insurance. Among CSHCN with family incomes above 100% of FPL, SSI enrollment decreases dramatically, primarily because many fewer children in families with survey-reported income above 100% of FPL are income eligible for the program.

3. We trend the data in **Table 1** forward to 2005 and adjust for missing data on income and private insurance status. In the 2001 CSHCN survey, there are an estimated 707,000 children receiving SSI. Program administrative data indicated that there were 844,000[4] children receiving SSI in December 2000. The difference between the survey and administrative data are likely due to missing data in the survey and a small amount of under-reporting of SSI coverage in the survey. SSI enrollment for children grew between December 2001 and December 2005, reaching 1,034,000[5] in December 2005. We assume that SSI enrollment grew in each income and private insurance category proportionally.

   We adjust for missing data in the 2001 survey, again assuming that CSHCN with missing data on income or private insurance status are distributed proportionally to children without missing data, and we trend the 2001 count of the number of children to 2005 using data from the census on the growth in the number of children between 2001 and 2005. The trended and adjusted data are shown in **Table 2.**

Table 1. Proportion of CSHCN, 0-17, receiving SSI, by family income and private insurance status, 2001

Family Income (% of FPL)	Without Private Insurance		With Private Insurance	
	Number of CSHCN	% Receiving SSI	Number of CSHCN	% Receiving SSI
< 100%	782,695	28.0%	283,255	18.4%
100-200	871,943	17.6%	998,643	8.3%
200-300	253,470	12.3%	1,288,119	3.8%
300-400	110,172	10.6%	1,293,996	3.1%
400% +	105,216	16.0%	2,302,272	2.2%
Total	2,123,496	20.4%	6,166,285	4.5%

Number of CSHCN with missing data on insurance, income, or SSI receipt: 1,030,000.

Source: 2001 National Survey of CHSCN.

Table 2. Proportion of CSHCN, 0-18 receiving SSI, by family income and private insurance status, estimates for 2005

Family Income (% of FPL)	Without Private Insurance		With Private Insurance	
	Number of CSHCN	% Receiving SSI	Number of CSHCN	% Receiving SSI
< 100%	960,371	35.7%	347,556	23.5%
100-200	1,069,879	22.5%	1,225,341	10.6%
200-300	311,009	15.7%	1,580,529	4.9%
300-400	135,182	13.5%	1,587,741	3.9%
400% +	129,101	20.4%	2,824,901	2.8%
Total	2,605,542	26.0%	7,566,067	5.7%

Source: 2001 National Survey of CHSCN.

Note: Estimates for 2005 are constructed by multiplying the numerator of the 2001 estimates by the ratio of (1,034,000/707,442) (which is the ratio of the number of < 18 SSI recipients in 2005 to the number of < 18 CSHCN SSI recipients in the 2001 NSCHSCN), and further multiplying this number by 1.07 to include 18 year olds, and multiplying the denominator of the 2001 estimates by the estimated growth in the < 18 population from 2001 to 2005 (which is 2%), by the ratio (9.32/8.39) (which is the ratio of the estimated number of CSHCN in the 2001 data divided by the estimated number of the CSHCN in the 2001 data with valid data for income, private insurance status, and SSI receipt), and by 1.07 to account for the inclusion of 18 year olds in the final estimates.

4. Because the FOA extends Medicaid eligibility to youth who are 18 years old, and both the National Survey of Children With Special Health Care Needs and Social Security Administration data only include youth through the age of 17, we make an additional adjustment in **Table 2** to increase the number of potentially eligible children at each income level and for each insurance category by 7%. This percent was derived by examining Social Security Administration data by age category. Since youth aged 13-17 represent approximately 35% of all children on SSI across a 5-year spread, we assume an equal distribution of 7% per year in this age spread, and so we add another 7% to the total number of "children" on SSI to account for 18-year-olds, as well as to the numerator of children potentially eligible for coverage under the FOA.

5. As shown in **Table 2,** we estimate that approximately 36% of CSHCN below 100% of FPL without private insurance were enrolled in SSI in 2005. The percentage enrolled in SSI drops to 22% among CSHCN between 100% and 200% of FPL, and to 16% among CSHCN between 200% and 300% of FPL. Among children who are covered by private insurance, the SSI percentages are 23%, 11%, and 5% for CSHCN in the three income groups.

6. As discussed above, we assume that if a state implements the FOA and increases income eligibility for Medicaid up to 300% of FPL, the fraction of CSHCN who enroll in Medicaid in families between 100% and 300% of FPL will increase to levels that are close to, although not equal to, the fraction of children below 100% of FPL who are currently enrolled in SSI. As shown in **Table 3,** we assume that enrollment in Medicaid will increase to 32% among CSHCN in families with incomes between 100% and 200% of FPL, and 28% in families with incomes between 200% and 300% of FPL. These estimates are close to the 36% of CSHCN below 100% of FPL who are enrolled in SSI, but clearly somewhat lower than that figure.

   We have estimated the income-gradient in enrollment using our best judgment and analysis of the income-gradient in enrollment in SCHIP. In making these estimates we assume that a state will impose nominal premiums for coverage. If premiums are higher, enrollment is likely to be substantially lower than we have estimated here. In making these estimates we have not made any explicit adjustment for differences in the

prevalence of disability among CSHCN above 100% of FPL. The Catalyst Center is currently working on an analysis to estimate whether there is less disability among CSHCN as income increases; if that analysis indicates that the level of disability among CSHCN does decline with family income, we will adjust estimated Medicaid participation downwards among children above 100% of FPL.

Similarly, among CSHCN with private insurance, we assume that Medicaid participation will be 19% in families with incomes between 100% and 200% of FPL, and 15% in families between 200% and 300%, compared to an SSI enrollment rate of 23% among CSHCN in families with incomes below 100% of FPL. The caveats about our assumptions regarding children without private insurance also apply to these estimates for children with private insurance.

Under these assumptions, as shown in **Table 3,** an estimated 133,000 children without private insurance and an estimated 247,000 children with private insurance would enroll in Medicaid under the FOA, *if* it were true that none of these children were currently eligible for Medicaid or SCHIP. (See #8 for adjustments to these estimates in states with SCHIP coverage up to 200% of FPL).

7. In the next step, we adjust the national numbers for different state circumstances. In the example, we use the 2001 national survey of CSHCN to estimate the number of CSHCN in a specific state in each income group and for each insurance status (private or public), adjusting the numbers for missing survey data on income or insurance status. The 2001 data then is trended forward to 2005 using the national growth rate in the number of children.

8. The next adjustment estimates the impact of the FOA on changes for children without private coverage between 100% and 200% of FPL. This is dependent on the configuration of the SCHIP program in each state, specifically the financial eligibility criteria and the comparability of SCHIP and Medicaid benefits. In this example, we assume all children without private insurance under 200% of FPL are eligible for SCHIP and that the SCHIP benefits are comparable to Medicaid benefits. Therefore, children between 100% and 200% of FPL who become eligible for Medicaid under the FOA are already eligible for SCHIP and are likely to be enrolled in the program already. While a few children may switch from SCHIP to Medicaid after the FOA is implemented, it will not have a

Table 3. Estimated nationwide effect of FOA on enrollment in Medicaid, 2005

Family Income (% of FPL)	Without Private Insurance					With Private Insurance					Total
	Number of CSHCN	Estimated 2005 SSI Enrollment	Estimated Enrollment in Medicaid Post-FOA	Difference	Estimated Number of FOA Children	Number of CSHCN	Estimated 2005 SSI Enrollment	Estimated Enrollment in Medicaid Post-FOA	Difference	Estimated Number of FOA Children	
100-200	1,069,879	22.5%	32%	9.5%	101,879	1,225,341	10.6%	19%	8.4%	102,966	
200-300	311,009	15.7%	28%	12.3%	38,185	1,580,529	4.9%	15%	10.1%	159,714	
Total					140,065					262,680	**402,745**

major impact on costs since the benefits are comparable across programs. In states where SCHIP eligibility is less than 200% of FPL or SCHIP benefits are substantially different from Medicaid benefits, different adjustments must be made.

9. Using Congressional Budget Office (CBO) estimates,[6] we multiply the number of children eligible for coverage under the FOA by the average cost of coverage for SSI-enrolled Medicaid children. That is, we multiply the number of FOA-eligible children with private insurance by $7,000, and the number without private insurance by $12,800 to obtain the full cost of covering these children. The CBO cost estimates use 2006 as the base, thus we trend this amount forward by 5% per year to 2008.

10. In the last step, we calculate the cost to the state general fund of implementing the FOA by subtracting the FMAP (Federal Medical Assistance Percentage), i.e., the portion of the total expenditures that will be paid by the federal government.

For Further Information

For further information about the Catalyst Center's methodology or obtaining a state-specific impact estimate, please contact Meg Comeau, Project Director, at 617-426-4447, extension 27, or mcomeau@bu.edu.

---

[1] For example, the model assumes a ceiling of 200% of FPL for SCHIP eligibility.

[2] Children with Special Health Care Needs

[3] 2001 National Survey of Children with Special Health Care Needs. Data for estimates were obtained from the National Survey of Children with Special Health Care Needs Data Resource Center, http://www.cshcndata.org.

[4] 2006 Annual Report of the SSI Program, http://www.ssa.gov/OACT/SSIR/SSI06/tables.html.

[5] Ibid.

[6] Congressional Budget Office Cost Estimate, S. 622 Family Opportunity Act of 2003, September 23, 2003, http://www.cbo.gov/showdoc.cfm?index= 4570&sequence=0.

Table 4. Estimated FOA effect on enrollment and Medicaid expenditures, [Sample State], 2005

		Without Private Insurance	With Private Insurance	Selected Totals	Catalyst Center Methodology Ref.
Estimated number of CSHCN in [State]					
Family Income (% of FPL)	100-200	1,747	3,245		Section 1 (page 2)
	200-300	473	4,304		
	Total	2,220	7,549		
Estimated percentage point increase in Medicaid in [State]					
Family Income (% of FPL)	100-200	9.5%	8.4%		Section 6 (pages 5-6)
	200-300	12.3%	10.1%		
Estimated FOA effect on enrollment					
Family Income (% of FPL)	100-200	9.5%	8.4%		Section 7 (page 6)
	200-300	12.3%	10.1%		
FOA enrollment adjusted for SCHIP					
Family Income (% of FPL)	100-200	0	273		Section 8 (pages 6, 8)
	200-300	58	435		
	Total	58	708	766	
Estimated 2006 Medicaid expenditures per child (Federal and State)		$12,800	$7,000		Section 9 (page 8)
State Medicaid Percentage		35.28%			Section 10 (page 8)
Estimated annual increase in Medicaid expenditures per child		5%			Section 9 (page 8)
[State] General Fund Expenditures, 2008		$288,875	$1,926,684	$2,215,559	Section 10 (page 8)

CATALYST CENTER

Table 5. Supplementary Data, [Sample State]

	United States	[State]
Number of children in SSI, 2005[4]	1,034,000	952
Number of children in SSI, 2001[3]	707,442	N/A
Number of children 0-17, 2001	73,119,741	158,451
Number of CSHCN 0-17, 2001	9,356,463	19,651
2005 SSI/CSHCN	10.8%	4.7%
CSHCN/All children	12.8%	12.4%
Children in SSI/All children	1.4%	0.6%
CSHCN without private insurance		
100%-200% FPL	980,281	1,601
200%-300% FPL	284,963	433
CSHCN with private insurance		
100%-200% FPL	1,122,724	2,973
200%-300% FPL	1,448,167	3,944
% CSHCN without private insurance		
100%-200% FPL	10.5%	8.1%
200%-300% FPL	3.0%	2.2%
% CSHCN with private insurance		
100%-200% FPL	12.0%	15.1%
200%-300% FPL	15.5%	20.1%

 The Catalyst Center is funded by the Maternal and Child Health Bureau of the Health Services and Resources Administration, U.S. Department of Health and Human Services, under grant #U41MCO4494.