U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

Cost Estimates for the Long-Term Care Provisions Under the Health Security Act

March 1994

Office of the Assistant Secretary for Planning and Evaluation

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This discussion paper was prepared by DALTCP as a follow-up document to Health Care Reform activities. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the office at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. The e-mail address is: webmaster.DALTCP@hhs.gov.

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TABLE OF CONTENTS

LIST OF TABLES

The Health Security Act contains four key elements related to long-term care which required cost estimates:

- A new home and community-based services (HCBS) program for persons with severe disabilities.

- Medicaid institutional care changes.

- Federal tax incentives and regulatory requirements for private long-term care insurance.

- Federal tax credits for personal assistance services (PAS).

This document describes the methodology and assumptions used in developing the cost estimates for the long-term care provisions under the Health Security Act.

I. OVERVIEW OF COST ESTIMATES

Table 1 summarizes the additional Federal expenditures estimated for each of the long-term care provisions under the Health Security Act.

TABLE 1. Summary of Additional Federal Expenditures Under the Health Security Act (in billions)

	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	Total
New HCBS Program	$4.5	$7.8	$11.0	$14.7	$18.7	$56.7
Medicaid Institutional Care Changes	$0.4	$0.5	$0.5	$0.5	$0.5	$2.4
Long-Term Care Tax Incentives	$0.1	$0.4	$0.5	$0.7	$0.8	$2.5
Tax Credit for PAS	$0.1	$0.1	$0.1	$0.1	$0.1	$0.5
Total	$5.1	$8.8	$12.1	$16.0	$20.1	$62.1

A. The Home and Community-Based Services Program (HCBS)

The cost estimates were generated by constructing a national budget for home and community- based services. The budget represents the best estimates of the Long-Term Care Working Group of the cost of providing an adequate level of services to the target population of persons with severe disabilities. The budget takes into account the number of persons with severe disabilities and their likely service use rates. The budget is composed of: (1) funds currently being spent for home and community-based services under the Medicaid program and under special State programs; (2) a substantial amount of new Federal funding, which would be matched by the States at a generous Federal match rate; and (3) funds collected from consumer cost-sharing. The national budget is designed for a fully implemented program. However, the program itself is phased in over seven years. The program becomes fully phased in during FY 2002, but FY 2003 is the first fiscal year in which all four quarters are at 100 percent of funding. If the new program is enacted, new Federal expenditures would be $56.7 over the FY 1996 to FY 2000 period.

B. Medicaid Institutional Changes

It is estimated that an additional $2.4 billion in Federal funds will be spent on Medicaid institutional residents over the period FY 1996 to FY 2000. These funds would be used to increase the personal needs allowance, to provide nursing facility coverage for the medically needy in States which do not currently offer such benefits, and to enable the States, at their option, to increase the amount of personal assets to $12,000 for unmarried persons in institutions.

C. Long-Term Care Tax Incentives and Regulatory Requirements

Although this portion of the long-term care program will not require any Federal funds, it will result in lower tax revenue. An estimated $2.5 billion in lost tax revenue over the FY 1996 to FY 2000 period will be incurred to promote private long-term care insurance through changes in allowable medical expenses deductions and the exclusion of employer-paid long-term care insurance premiums from taxable income.

D. Tax Credit for Personal Assistance Services

An estimated $0.5 billion in tax credits for personal assistance expenses for employed persons with disabilities would be incurred over the FY 1996 to FY 2000 period. The Health Security Act would provide a nonrefundable tax credit for up to 50 percent of a person's with disabilities personal assistance services (PAS) expenses up to the lesser of $15,000 or the individual's earned income. The tax credit would be phased down for taxpayers with modified aggregate gross income (AGI) over $50,000.

II. OVERVIEW OF METHODOLOGY FOR COST ESTIMATES

For persons age 65 and older, we used the Brookings-ICF Long-Term Care Financing Model to develop projections of long-term care expenditures under current policy and to estimate the impact of the alternative proposals. For persons under age 65, we developed a spreadsheet model to estimate expenditures for three types of institutional care (nursing facilities, intermediate care facilities for the mentally retarded (ICF-MR) by size of facility, and large non-certified facilities). For community-based services, we used the spreadsheet model to estimate costs for two age groups (children and adults age 18-64) and for two different types of disability (functional or ADL measures and mental retardation/developmental disability (MR/DD) indicators). For the community-based MR/DD population, the model further differentiated those in group residential settings and those with severe or profound mental retardation who were not in group residential settings.

The general methodology for evaluating each proposal involved estimating the following:

- the number of persons eligible for each program component;
- a program participation rate--i.e., how many of the eligible population would actually receive services/benefits under each program component;
- a use rate (average number of visits or days) for services covered by the program component;
- the level of induced demand--demand for services could increase to the extent that various program components lower out-of-pocket costs;
- the cost per visit, day, or month under the program;
- public and private spending, including copayment requirements from beneficiaries; and
- the amount of public (Federal and State) spending under the proposal compared to public spending under current policy.

Projecting these estimates into the future requires a large number of assumptions. The most important assumptions include:

- Population growth rates and mortality will be equal to those in the Social Security Actuary's Level II assumptions.

- Disability rates will remain constant on an age/sex basis over time.

- In the long run, prices for long-term care services will increase at the same rate as the compensation of workers in the economy (1.5 percent real growth)--this can be divided into 1.1 percent real wage growth and 0.4 percent real growth in fringe benefit costs.

- Economic growth will be equal to the rate of growth projected by the Council of Economic Advisers' assumptions.

- Demand will increase if prices are reduced, particularly for home and community-based services.

- The supply of services will expand to respond to demand.

A. Data Used

The following datasets were used to estimate long-term care utilization and expenditures:

- The 1982-84 National Long-Term Care Survey (NLTCS) was used to estimate the use of home and community-based services and nursing home admissions b disabled elderly in the Brookings- ICF Long-Term Care Financing Model. The 1989 NLTCS was used to determine the number of elderly persons likely eligible for the program.

- The 1985 National Nursing Home Survey (NHHS) was used to estimate the use of nursing home care in the Brookings-ICF Long-Term Care Financing Model.

- The 1987 National Medical Expenditure Survey (NMES) Household and Institutional sample was used to estimate the use and cost of home and community-based and nursing facility services among the non-elderly and the use of ICFs-MR and non-certified large facilities (16 or more beds); it was also used to estimate the use of residential group settings in the community among the MR population. The NMES data were adjusted for an undercount of small facilities per Project Report 29 from the Center for Residential and Community Services, Institute on Community Integration, University of Minnesota.

- The 1990 Survey of Income and Program Participation (SIPP) was used to estimate the number of functionally disabled working-age (18-64) persons based on activity of daily living (ADL) measures and the number of persons with mental retardation and other developmental disabilities.

- The Current Population Survey (CPS) is the basis of the underlying population data in the Brookings-ICF Long-Term Care Financing Model.

- Administrative data from HCFA on Medicare home health and skilled nursing facility use and expenditures and Medicaid nursing facility, ICF-MR, and home and community-based services use and expenditures were used to provide information on the per unit costs of services.

B. Current Law Expenditures

In order to estimate the cost of alternative proposals, we had to develop estimates of long-term care expenditures under current law. We developed detailed expenditure estimates for the year 1993, 2000, and 2020. These estimates include Medicaid projections provided by the HCFA actuaries through fiscal year 2000. These estimates for the total population, elderly persons and non-elderly persons are shown in Table 2, Table 3 and Table 4. We also estimated spending in the intervening years during the phase in of the program--1996 to 2003.

TABLE 2. Estimated Long-Term Care Expenditures Under Current Law For All Age Groups (amounts in billions of constant 1993 dollars)

	Institutional			Home and Community-Based			Total		
	1993	2000	2020	1993	2000	2020	1993	2000	2020
TOTAL	75.2	99.7	180.7	32.6	49.7	76.4	107.8	149.4	257.1
Total Public	45.5	62.2	104.6	23.6	38.7	56.7	69.1	100.9	161.3
Medicare	5.7	7.4	15.1	10.1	18.8	31.1	15.8	26.2	46.2
Medicaid	36.3	50.9	83.5	7.4	13.6	16.4	43.7	64.5	99.9
Federal	20.6	28.9	47.4	4.1	7.5	9.1	24.7	36.4	56.4
State	15.7	22.0	36.1	3.3	6.1	7.3	19.0	28.1	43.4
Other	3.5	3.9	6.0	6.1	6.3	9.2	9.6	10.2	15.2
Federal	1.0	0.9	1.2	1.6	1.7	2.3	2.6	2.6	3.5
State	2.5	3.0	4.8	4.5	4.6	6.9	7.0	7.6	11.7
Total Private	29.7	37.5	76.1	9.0	11.0	19.7	38.7	48.5	95.8
Out-of-Pocket and Other	29.6	36.7	69.3	8.9	10.7	17.0	38.5	47.4	86.3
Long-Term Care Insurance	0.1	0.8	6.8	0.1	0.3	2.7	0.2	1.1	9.5

TABLE 3. Estimated Long-Term Care Expenditures For Elderly Under Current Law (amounts in billions of constant 1993 dollars)									
	Institutional			Home and Community-Based			Total		
	1993	2000	2020	1993	2000	2020	1993	2000	2020
TOTAL	58.6	78.8	148.6	20.6	33.1	54.0	79.2	112.0	202.7
Total Public	30.3	42.7	75.2	15.3	26.3	40.6	45.6	69.1	115.9
Medicare	5.5	7.1	14.5	9.4	17.5	29.4	14.9	24.7	44.0
Medicaid	23.5	34.3	58.6	3.8	6.5	8.2	27.3	40.8	66.8
Federal	13.3	19.5	33.3	2.1	3.6	4.5	15.4	23.0	37.8
State	10.2	14.8	25.3	1.7	2.9	3.7	11.9	17.7	29.0
Other	1.3	1.3	2.1	2.1	2.3	3.0	3.4	3.6	5.1
Federal	0.7	0.7	0.7	1.6	1.7	2.3	2.3	2.4	3.0
State	0.6	0.6	1.4	0.5	0.6	0.7	1.1	1.2	2.1
Total Private	28.3	36.1	73.4	5.3	6.8	13.4	33.6	42.9	86.8
Out-of-Pocket and Other	28.2	35.3	66.6	5.2	6.5	10.7	33.4	41.8	77.3
Long-Term Care Insurance	0.1	0.8	6.8	0.1	0.3	2.7	0.2	1.1	9.5

TABLE 4. Estimated Long-Term Care Expenditures For Children and Working-Age Adults Under Current Law (amounts in billions of constant 1993 dollars)									
	Institutional			Home and Community-Based			Total		
	1993	2000	2020	1993	2000	2020	1993	2000	2020
TOTAL	16.6	20.9	32.1	12.0	16.6	22.3	28.6	37.4	54.4
Total Public	15.2	19.5	29.4	8.3	12.4	16.0	23.5	31.8	45.4
Medicare	0.2	0.2	0.6	0.7	1.3	1.6	0.9	1.5	2.2
Medicaid	12.8	16.7	24.9	3.6	7.1	8.2	16.4	23.8	33.1
Federal	7.3	9.5	14.1	2.0	3.9	4.5	9.2	13.4	18.6
State	5.5	7.2	10.8	1.6	3.2	3.7	7.1	10.4	14.4
Other	2.2	2.6	3.9	4.0	4.0	6.2	6.2	6.6	10.1
Federal	0.3	0.2	0.5	0.0	0.0	0.0	0.3	0.2	0.5
State	1.9	2.4	3.4	4.0	4.0	6.2	5.9	6.4	9.6
Total Private	1.4	1.4	2.7	3.7	4.2	6.3	5.1	5.6	9.0
Out-of-Pocket and Other	1.4	1.4	2.7	3.7	4.2	6.3	5.1	5.6	9.0
Long-Term Care Insurance	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

III. HOME AND COMMUNITY-BASED SERVICES (HCBS) PROGRAM

The new home and community-based services program significantly expands funding of HCBS for persons with severe disabilities without regard to the financial status of those seeking services. Persons with severe disabilities are defined as being in one of the following groups:

- Individuals requiring hands-on, standby, or cueing assistance to perform three or more out of five activities of daily living (bathing, eating, dressing,-toileting, and transferring).

- Individuals with severe cognitive or mental impairment.

- Individuals with severe or profound mental retardation.

- Children with a severe disability or chronic medical condition that would otherwise require institutionalization.

Personal assistance services must be provided in all States that opt to participate in the program. In addition, States can also provide case management; homemaker and chore assistance; home modifications; respite services; assistive devices; adult day services; habilitation and rehabilitation; supported employment; home health services or any other services. The program calls for flexibility in meeting participants' needs. State may offer vouchers or cash payments to recipients.

Table 5 projects baseline spending, the cost of the new program, and the net impacts of the new program. Over the period FY 1996-FY 2000 under current law $19.1 billion in Federal Medicaid funds are estimated to be spent on home and community-based services for persons with severe disabilities. States are expected to spend $15.5 billion on home and community-based services under Medicaid and $9.3 billion on State-only funded programs for persons with severe disabilities over the same period.

If the new program is enacted, the Federal HCBS budget is estimated to be $70.5 billion over the period FY 1996-FY 2000, consisting of $56.7 billion in new Federal dollars and $13.8 billion in Federal Medicaid funds that are transferred to the new program. If all States match their full Federal allotment, they would spend $13.5 billion under the new program over the FY 1996-FY 2000 period. Individuals with income greater than 150 percent of the poverty level would spend $8.2 billion on copayments under the program over the same period. In addition to the expenditures under the new program, Medicaid home and community-based services will continue to be available after the new program is implemented for low income persons with less than severe disabilities, as well as for those with severe disabilities.

TABLE 5. Estimated Expenditures Under New Home and Community-Based Services Program										
	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	Five Year Sum	FY 2001	FY 2002	FY 2003	Eight Year Sum
Current Law Spending										
Federal Medicaid HCBS Spending	$4,787	$7,200	$7,818	$8,796	$9,613	$38,214	$10,650	$11,798	$13,071	$73,733
Severely Disabled	$2,393	$3,600	$3,909	$4,398	$4,807	$19,107	$5,325	$5,899	$6,535	$36,867
Other Disabled	$2,393	$3,600	$3,909	$4,398	$4,807	$19,107	$5,325	$5,899	$6,535	$36,867
State Medicaid & State Only	$5,199	$7,694	$8,314	$9,208	$9,949	$40,363	$10,858	$11,858	$12,957	$76,036
Medicaid	$3,893	$5,856	$6,359	$7,154	$7,819	$31,081	$8,662	$9,596	$10,631	$59,969
Severely Disabled	$1,947	$2,928	$3,179	$3,577	$3,909	$15,540	$4,331	$4,798	$5,315	$29,985
Other Disabled	$1,947	$2,928	$3,179	$3,577	$3,909	$15,540	$4,331	$4,798	$5,315	$29,985
State Only for Severely Disabled	$1,306	$1,838	$1,955	$2,054	$2,130	$9,283	$2,196	$2,262	$2,326	$16,067
Total Public	$9,986	$14,894	$16,132	$18,003	$19,562	$78,577	$21,508	$23,656	$26,027	$149,769
Reform										
New Program										
Total Federal[1]	$5,929	$10,111	$13,819	$18,080	$22,582	$70,522	$31,291	$40,817	$44,150	$186,780
New Funds	$4,500	$7,800	$11,000	$14,700	$18,700	$56,700	$26,700	$35,500	$38,300	$157,200
Medicaid Offset[2]	$1,429	$2,311	$2,819	$3,380	$3,882	$13,822	$4,591	$5,317	$5,850	$29,580
Total State	$1,145	$1,950	$2,646	$3,449	$4,288	$13,479	$5,963	$7,791	$8,503	$35,736
New Funds	$869	$1,504	$2,106	$2,804	$3,551	$10,837	$5,088	$6,776	$7,377	$30,077
Medicaid Offset[2]	$276	$446	$540	$645	$737	$2,642	$875	$1,015	$1,127	$5,659
Total Public Under Program	$7,074	$12,061	$16,466	$21,529	$26,871	$84,001	$37,254	$48,608	$52,653	$222,516
New Funds	$5,369	$9,304	$13,106	$17,504	$22,251	$67,537	$31,788	$42,276	$45,677	$157,277
Medicaid Offset[2]	$1,705	$2,757	$3,359	$4,025	$4,620	$16,464	$5,466	$6,331	$6,977	$35,239
Coinsurance Amounts	$658	$1,158	$1,606	$2,119	$2,663	$8,203	$3,738	$4,894	$5,301	$22,126
Total	$7,732	$13,219	$18,071	$23,648	$29,533	$92,204	$40,981	$53,502	$57,955	$244,642
Continuing Medicaid Program										
Federal	$3,092	$4,535	$4,690	$5,127	$5,478	$22,923	$5,821	$6,206	$6,918	$41,867
State	$2,618	$3,836	$3,954	$4,306	$4,581	$19,297	$4,827	$5,105	$5,698	$34,926
Total	$5,710	$8,372	$8,644	$9,434	$10,060	$42,220	$10,647	$11,311	$12,615	$76,794
Net Impact of Program on States										
Change in State Expenditures[3]	-$1,436	-$1,907	-$1,713	-$1,452	-$1,079	-$7,588	-$69	$1,039	$1,244	-$5,374
Percent Calendar Year Phase	20%	30%	40%	50%	60%		80%	100%	100%	

FOOTNOTES:

1. Total Federal Expenditures Under New Program--Includes both new Federal funds appropriated for the program under the Health Security Act and Medicaid expenditures transferred to the new program.
2. Assumed Fed. Medicaid Offset--The Federal Medicaid funds transferred to the national budget based on an estimate of the extent to which that States will demonstrate reduced Medicaid home and community-based expenditures for persons with severe disabilities. This estimate reflects more recent data that were not available at the time the President's FY 95 Budget was prepared.
3. Change in State Expenditures--Difference in State expenditures under the program and under current law. These estimates assume States will use some portion of current State Medicaid expenditures to match the Federal funds under the new program with the higher Federal match rate. This will allow many States to serve more people and spend less funds than under current law.

NOTE: Current law for Medicaid as estimated by the Health Care Financing Administration (HCFA) Office of the Actuary for the President's FY 1995 budget.

Federal expenditures under the new program consist of allocated funds from the legislation and Federal Medicaid offset amounts. Federal Medicaid offset amounts included in the national budget are based on our estimate of the proportion of Federal Medicaid expenditures which will be shifted to the new program as States take advantage of the higher match rates. The exact amount of Medicaid offset amounts to be included in the national budget will be based on a determination by the Secretary of HHS of how much States have collectively reduced their Medicaid HCBS expenditures as a result of transferring eligible Medicaid recipients to the new program.

States would spend $13.5 billion under the new program if they all matched their full Federal allotments. Some of the State spending under the new program includes funds that would have otherwise been spent on persons with severe disabilities under their ongoing Medicaid program. In addition, we assume that States will maintain Medicaid home and community-based spending for persons with severe disabilities of approximately $3.76 billion over the FY 1996-FY 2000 with a Federal match of $3.82 billion.[1]

The net impact of the new program over the FY 1996-FY 2000 period would be an additional $56.7 billion Federal expenditures for home and community-based services, and $7.6 billion in savings to States. The estimates of the reduction in State expenditures assume States will use portions of current Medicaid expenditures in conjunction with the higher Federal match rate to serve more persons.

A. Eligible Population

Table 6 shows estimates of the total number of disabled persons by level of disability in the United States.

TABLE 6. 1993 Estimate of Persons with Disabilities

Disability Level	Number in Thousands	Percent
Mild	5,450	53%
Moderate	1,750	17%
Severe (program eligibles)	3,090	30%
Total	10,290	100%

NOTE: In developing these estimates, persons with severe disabilities were classified first. Persons with mild disabilities are those with IADLs only, and persons with moderate disabilities have one or two ADL deficiencies.

The following tables provide estimates of the number of persons eligible for the new program by selected income level, age, and type of disability.

[1] During the phase-in period of the new HCBS program, some States may no have a sufficient Federal allotment under the new program to serve all of their Medicaid recipients with severe disabilities and also serve non-Medicaid participants without regard to income. In these States, the Medicaid expenditures for persons with severe disabilities that cannot be refinanced under the new program are assumed to be incorporated into the continuing Medicaid program. The $3.8 billion is the difference in current law expenditures for persons with less than severe disabilities and the total continuing HCBS Medicaid expenditures.

TABLE 7. 1993 Estimates of Persons with Severe Disabilities by Income as a Percent of the Poverty Level		
Income as a Percent of Poverty	**Number in Thousands**	**Percent**
Less than 100%	977	31.6%
100-149%	440	14.2%
150-199%	429	13.9%
200-249%	318	10.3%
250-299%	208	6.7%
300% or more	718	23.3%
Total	3,090	100.0%
NOTE: Income is based on income of the family unit. Under this definition, adult members not related by marriage are not considered part of the family and are considered separately. For example, a disabled adult living with his or her parent would be counted as a separate unit.		

TABLE 8. 1993 Estimates of Persons with Severe Disabilities by Age		
Age	**Number in Thousands**	**Percent**
Less than 65	985	32%
65 and over	2,105	68%
Total	3,090	100%

TABLE 9. 1993 Estimates of Persons with Severe Disabilities by Type of Disability		
Type of Disability	**Number in Thousands**	**Percent**
Severe Cognitive or Mental Impairment (e.g., Alzheimer's Disease or chronic mental illness)	1,250	40.5%
Severe or Profound MR/DD	270	8.7%
3+ ADLs	1,570	50.8%
Total	3,090	100.0%
NOTE: The hierarchy used to classify individuals was: those with severe or profound MR/DD; those with three or more ADL deficiencies; and those qualifying with a similar level of cognitive or mental impairment. Due to a lack of adequate data, children under age six who would qualify for the program have not been estimated separately.		

1. Medicare Eligibles

The estimated percent of persons who are Medicare eligible participating in the new HCBS program and the proportion of expenditures associated with this participation based on the fully phased-in program in 1993 are as follows:

- The percent of persons participating in the program who are Medicare beneficiaries would be 73 percent.

- The proportion of total expenditures under the program for Medicare beneficiaries would be 67 percent. This is less than the percent of participants because, on average, Medicare beneficiaries have lower annual expenditures than non-Medicare beneficiaries.

- The proportion of public expenditures under the program for Medicare beneficiaries would be 61 percent. This is less than the proportion of total expenditures because, on average, Medicare beneficiaries pay for a larger proportion of their care through copayments because they tend to have higher income than non-Medicare beneficiaries.

2. Medicaid Eligibles

It is difficult to provide reliable information on the proportion of current Medicaid recipients who could be covered under the new program because the Medicaid program does not collect this type of information on a nationwide basis.. We estimated that approximately 250,000 current Medicaid home and community-based services recipients in 1993 would meet the eligibility criteria for the new program and that these individuals currently receive approximately $11,000 annually in services. This $11,000 average benefit across all Medicaid recipients with severe disabilities is relatively high because of the high average benefit of persons with MR/DD in the waiver programs. The median Medicaid home and community-based benefit for Medicaid recipients with severe disabilities would be lower than $11,000. These estimates are based on three sources of data: the 1987 NMES; Medicaid Form 2082 data for 1992; and Medicaid HCFA Form 64 and 372 data for 1991, 1992 and 1993.

3. Data Sources for Estimates

The estimates presented above are based on the following data sources:[2]

- Children Under Age 18--We used both the 1989 National Health Interview Survey (NHIS) and the 1987 NMES to estimate the number of children under age 18 who need assistance with at least three of five ADLs.

- Working-Age Adults--For persons age 18 to 64, we relied on the 1990 SIPP to estimate the number of persons who required help with at least three of five ADLs, as well as those with severe chronic mental illness or Alzheimer's Disease. SIPP was also used to estimate the number of persons who have severe or profound mental retardation or developmental disabilities (MR/DD). Because SIPP does not have data on levels of MR/DD, we used data from the Center on Residential Services and Community Living at. the University of Minnesota to estimate the total number of community-dwelling persons with severe or profound MR/DD (approximately 220,000 in 1990).

- Elderly--We used the 1989 NLTCS to estimate the number of elderly who would be eligible. The NLTCS provides a large sample of elderly Medicare beneficiaries with disabilities that have lasted or are expected to last at least three months.

[2] In estimating the eligible population, we were limited by the available data. Measuring disability among very young children and persons with mental illnesses is very difficult. Also identifying specialized groups, such as persons with AIDS, and those with traumatic brain injuries is difficult. Therefore, those groups have not been identified separately in our estimates.

The data were used to estimate the number of persons who need assistance with at least three of five ADLs or a similar level of cognitive or mental impairment. A similar level of cognitive or mental impairment was defined as: (1) missing four of ten questions on the Short Portable Mini-Mental Status Questionnaire (SPMSQ); and (2) demonstrating one of the following: disability in at least one of the cognitive Instrumental Activities of Daily Living (IADLs) of medication management, money management, or telephoning; evidence of a behavior problem; or disability in one or more ADLs.

B. Participation Rate

Many persons with severe disabilities currently do not receive paid assistance. Most care is provided by family and friends. A new public program would be expected to increase the number of persons with paid assistance. In estimating the impact of a proposal, one must attempt to estimate the expected impact of reduced prices (due to the proposal) on the demand for care. The literature on price elasticities for long-term care services is limited. In general, the estimates assume that under a 20 percent copay (on average for those contributing to the cost of their care), demand for home and community-based services would increase by 100 percent.

For the elderly, the demand response in the Brookings-ICF Long-Term Care Financing Model is implemented by increasing the probability of using long-term care services. In a given year, if one assumes 100 percent induced demand, approximately 80 percent more elderly users among the eligible population will use paid home and community-based services than under current policy. In addition, those already using services will have 10 percent more visits. The average number of visits annually for persons with three or more ADLs who are using paid services under current law is approximately 120. When 100 percent induced demand is assumed, approximately 80 percent of the elderly population with three or more ADLs (or a similar level of cognitive or mental impairment), will use formal services and they will have approximately 130 visits per person annually.[3]

For persons up to age 65, participation estimates were based on the 1987 NMES. The induced demand results for the elderly were applied to the NMES percentage of persons using paid services and average number of visits. Specifically, the percent of persons using paid home and community-based services from the NMES data were increased by 80 percent and the average number of visits were increased 10 percent.

These induced demand assumptions result in the following participation rates:

Overall--77 percent
Severe or Profound MR/DD--77 percent

[3] About 45 percent of this population uses formal services under current law (45 percent x 1.8 equals 80 percent).

Children and working-age adults without severe or profound MR/DD--66 percent
Elderly--80 percent

C. Service Use and Cost

The payment rates and the assumptions used in estimating the unit cost for each group are summarized below.

- Payment rate for functionally disabled--456/visit in 1993 based on two sources: (1) average per visit cost from the 1987 NMES inflated to 1993; and (2) a blend of salaries of home makers, home health aides, and LPNs based on a survey of home health agencies with administrative overhead.[4]

- Payment rate for MR/DD--$85.72/day (approximately 65 percent of the payment rate for small ICFs-MR).

The following estimate of average use per recipient were used in estimating the cost of the program:

- Average Use for Elderly--The elderly were assumed to receive, on average, 130 visits (including the effects of induced demand). This average number of visits per recipient is based on results of the Brookings-ICF Long-Term Care Financing Model. The average expenditures would be $7,270 per recipients.[5]

  In estimating the cost of the program for the elderly, we assumed that program participants would enter and leave the program throughout the year. Therefore, the number of persons receiving services under the new program is greater than the number of persons eligible and participating at any given point in time. The estimates of eligibility presented above were based on the number of persons eligible at a point in time. In presenting the per user estimate in the summary table below, we have shown average annual total expenditures per elderly person at a cross-section (i.e., at a point in time, rather than per user throughout the year). This amount is equivalent to the cost of services if an individual participated in the program throughout the entire year. Using a cross- sectional estimate of the number of elderly persons who use at any given point results in average annual total expenditures of approximately $11,100 in 1993 (excluding Medicare visits) for the elderly.

- Average Use for Persons with MR/DD--We assumed that those with MR/DD would have average annual total expenditures of $31,290 in 1993. This is

[4] Hospital Compensation Service, "Home Care Salary and Benefits Report: 1991-92," John R. Zabka Associates, Inc.: Oakland, NJ, 1991).

[5] The average annual total expenditures were calculated by multiplying the average number of visits during the year (130) by the rate per visit in 1993 ($56/visit).

consistent with the average expenditures per recipient for persons served under Medicaid MR/DD) Home and Community- Based Waivers. This average annual expenditures is also consistent with,65 percent of the average annual expenditures per recipient in ICF/MR facilities of 15 beds or less,[6] where 65 percent was used as a -proxy for the non-room and board portion of Medicaid payments. The relatively high estimated cost of serving persons with MR/DD under the program reflect our assumption that the majority of persons will receive services in 24-hour licensed residential care facilities. Under the Medicaid Home and Community-Based Waiver program, approximately two-thirds of MR/DD Waiver recipients reside in such facilities.

- Average Use for Non-Elderly--The non-elderly were assumed to receive, on average, 141 visits (including the effects of induced demand). The average number of visits is based on data from the 1987 NMES. This results in an average total cost of $7,900 per recipient in 1993.[7]

Table 10 provides 1993 estimates of average expenditures per eligible person and per user under the fully phased-in program.

TABLE 10. Average Expenditures

	Average Annual Total Expenditures		Average Annual Public Expenditures	
	Per Eligible	**Per User**	**Per Eligible**	**Per User**
Total	$9,320	$12,150	$8,415	$10,970
MR/DD	$24,095	$31,290	$24,095	$31,290
Children and Working-Age Adults	$5,285	$7,900	$4,785	$7,600
Elderly	$8,840	$11,100	$7,950	$9,940

NOTE: Expenditures per eligible is based on estimated expenditures divided by the number of persons eligible for the program. Expenditures per user is based on estimated expenditures divided by the number of persons participating in the program. Public expenditures are total expenditures less copayments from individuals.

Table 11 provides the estimated distribution of program expenditures by eligibility criteria.

[6] Congressional Research Service, "Medicaid Sourcebook: Background and Data Analysis," for the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, U.S. House or Representatives, January 1993, p.898.

[7] The average annual total expenditures were calculated by multiplying the average number of visits during the year (141)by the rate per visit in 1993 ($56/visit).

TABLE 11. Percent Distribution of Program Expenditures Under Fully Phased in Program, 1993		
Type of Disability	**Public Expenditures**	**Total Expenditures**
Severe Cognitive or Mental Impairment (e.g., Alzheimer's Disease or chronic mental illness)	33.3%	34.3%
Severe or Profound MR/DD	25.0%	22.4%
3+ ADLs	41.7%	43.3%
Total	100.0%	100.0%
NOTE: The heirarchy used to classify individuals was: those with severe or profound MR/DD; those with three or more ADL deficiencies; and those qualifying with a similar level of cognitive or mental impairment. Due to a lack of adequate data, children under age six who would qualify for the program have not been estimated separately.		

D. Financing

The program is financed by Federal appropriations, State matching funds, and participant copayments. The Federal appropriation is specified in the Health Security Act each year through fiscal year 2003. The amount of new Federal funds is shown in Table 12.

TABLE 12. New Federal Funds		
	Calendar Year Phase-In	**Fiscal Year Federal Allocation (in billions)**
1996	20%	$4.5
1997	30%	$7.8
1998	40%	$11.0
1999	50%	$14.7
2000	60%	$18.7
2001	80%	$26.7
2002	100%	$35.5
2003	100%	$38.3
NOTE: Amounts do not include Medicaid expenditures that can be incorporated into the Federal budget. Amounts are shown through Fiscal Year 2003 because this is the first full fiscal year at full funding because the phase-in is based on a calendar year.		

In addition to the amounts stated in the legislation, to the extent that States demonstrate reduced Medicaid home and community-based expenditures for the eligible population, these amounts could increase the Federal funds available. This increase in funds does not accrue directly to an individual State, but rather to the total amount available to the national Budget. Any increase resulting from Medicaid reductions would be distributed to the States based on their share of Federal funds from the allocation formula.

1. Impact of New Program on Current Law Programs

In estimating the increased total and public expenditures under the new program we made the following assumptions regarding other current law public programs that provide home health or home and community-based services:

- Medicare--Assumed unchanged except for imposition of 10 percent copayment requirement under the HSA for home health services.

- Other Federal Sources (OAA & VA)--Assumed unchanged.

- State Supported Programs--State-only expenditures for persons with severe disabilities were assumed to be used to draw down Federal funds under the new program; State spending for other populations assumed to remain unchanged.

- Medicaid--Current law for Medicaid estimated by the Health Care Financing Administration (HCFA) Office of the Actuary for the President's FY 1995 budget. One-half of current Medicaid home and community-based services spending was assumed to be for persons eligible for the program. One-half of current Medicaid home and community-based services spending were assumed to be for persons eligible for the program. In the cost estimates, one-half of current Medicaid expenditures (the assumed amount for persons with severe disabilities) was added to the available Federal funds specified in the legislation subject to restrictions described under the State Impact section. The assumption of one-half is based on national level data. In estimating State impacts we applied this same assumption to all States. This percentage most likely varies by State, but we had no data which permitted us to estimate the actual percentage on a State-by-State basis. Expenditures for Medicaid recipients not eligible for the new program were assumed to continue at a comparable level to current law. The estimate of one-half of current Medicaid home and community-based services expenditures for the eligible population is based on NMES data and HCFA form 64 and 372 data. For Home Health, Personal Care, and Home and Community-Based Waivers, the distribution among all elderly, adult disabled and children who are Medicaid home and community-based services recipients and the subset that would be eligible for the program is based on 1987 NMES data. These data indicate that approximately 50 percent of Medicaid expenditures are for those meeting the severely disabled criteria. The split between MR/DD Medicaid Home and Community-Based Waiver recipients and others is based on a Congressional Research Service paper by Richard Price ("Medicaid Home and Community-Based Care Program," 92-902 EPW). This report indicated that approximately 65 percent of Home and Community-Based Care Waiver expenditures in 1991 were for persons with MR/DD. Based on data from the 1987 NMES Institutional sample for residents of small (beds less than 16) MR facilities, we assumed that 47 percent of these expenditures were for persons with severe or profound MR/DD (those eligible for the program).

2. State Allocation Formula for Federal Funds

The allocation of Federal funds available under the program to the States will be based on the following formula:

> [(# of persons with severe disabilities by State * 80% of national average budget per eligible * wage index by State) + coinsurance adjustment amount calculated for each State] * State enhanced Federal match rate

The variables are defined as follows:

- # of person with severe disabilities--based on State population by age, sex, and income times national prevalence rates for severe disability[8] (see the prevalence rates shown in Table 13).

- national average budget per eligible--total estimated costs (public and private) divided by the number of severely disabled (see the total expenditure per eligible in Table 9). The 80 percent of the national average budget per eligible is based on the estimated public funds required if no cost-sharing assistance were provided to low-income participants. The low income adjustment accounts for an estimated 10 percent of total expenditures under the program that would be used to assist low-income participants with cost-sharing. The remaining 10 percent of estimated total expenditures is estimated to be paid by participant cost-sharing

- wage index by State--based on average hourly wages for service workers other than protective services from the 1990 Census

- coinsurance adjustment amount--(# of severely disabled by State * 10% of national average budget per eligible * wage index by State * low income index by State)

- low income index--based on the ratio of the percent of the population below 150 percent of the poverty level in each State from the 1990 Census divided by the national percentage

- enhanced Federal match rate--FMAP + 28 points up to a maximum of 95 percent

Once a State's share of the total Federal budget is determined, the amount of Federal funds available to each State during the phase-in is based on the State's share derived from the formula described above divided by the sum of these amounts for all States. For example, if the amount from the formula for a State is $700 million and the total amount for all States is $25 billion, the State share of Federal funds is 2.8 percent (0.7/25). The State would be allocated 2.8 percent of the Federal funds available in

[8] These estimates were based on 1990 Census data which were updated to 1993 based on data from the March Current Population Survey.

each fiscal year. The percentage share for a State could vary from year to year based on the updates of the data used in the formula.

Table 13 provides the prevalence rate for persons with severe disabilities under the legislative definition by age, sex, and income as a percent of the poverty level. These prevalence rates were developed from the estimates above and applied to State population characteristics to estimate the number of persons potentially eligible for the new program by State.

TABLE 13. Rate Per 1,000 Persons Used for Severe Disabilities by Age, Sex, and Income as a Percent of the Poverty Level

Age/Sex	Income as a Percent of the Poverty Level				
	<100%	100-149%	150-199%	200-299%	300%+
Males					
<18	11.48	0.00	0.00	0.00	0.00
18-44	14.14	3.41	2.30	1.18	0.17
45-64	43.37	18.49	20.91	6.13	2.07
65-74	127.43	127.21	76.74	60.79	13.05
75-84	171.55	140.28	141.24	96.86	35.47
85+	561.32	405.63	264.61	204.40	108.66
Females					
<18	11.42	0.00	0.00	0.00	0.00
18-44	7.85	4.74	3.45	3.36	1.32
45-64	28.49	11.25	8.51	16.13	3.31
65-74	108.37	49.83	47.70	28.73	10.60
75-84	182.75	106.81	71.73	94.88	36.36
85+	459.70	360.79	184.95	308.87	78.68

Table 14 summarizes the assumptions used in estimating each State's share of the Federal allocation.[9] Table 15 shows the percentage of Federal allocation each State would receive.

TABLE 14. Assumptions Used in State Estimates Based on Allocation Formula

	Number of Severe Disabilities (in thousands)	Enhanced FMAP	Low Income Index	Wage Index
United States	3,090			
Alabama	64	95.00%	1.35	0.85
Alaska	3	78.00%	0.75	1.48
Arizona	45	93.89%	1.18	0.95
Arkansas	41	95.00%	1.47	0.84
California	302	78.00%	0.99	1.19
Colorado	32	82.42%	0.93	0.97
Connecticut	35	78.00%	0.51	1.34
Delaware	7	78.00%	0.70	1.05
District of Columbia	8	78.00%	1.13	1.43
Florida	206	83.03%	1.01	1.06

[9] The Territories of Guam, Puerto Rico, the Virgin Islands, American Samoa, and the Northern Mariana Islands may also receive Federal allocations under this program. Because we did not have data on the demographic and economic characteristics for these populations, they have not been included in our analysis.

TABLE 14 (*continued*)				
	Number of Severe Disabilities (in thousands)	**Enhanced FMAP**	**Low Income Index**	**Wage Index**
Georgia	77	90.08%	1.09	1.03
Hawaii	11	78.00%	0.68	1.30
Idaho	12	95.00%	1.17	0.82
Illinois	134	78.00%	0.87	1.02
Indiana	64	91.21%	0.88	0.89
Iowa	38	90.74%	0.95	0.81
Kansas	32	86.18%	0.95	0.85
Kentucky	55	95.00%	1.39	0.86
Louisiana	61	95.00%	1.61	0.87
Maine	16	89.81%	0.92	1.00
Maryland	47	78.00%	0.63	1.15
Massachusetts	74	78.00%	0.67	1.28
Michigan	108	83.84%	0.94	0.97
Minnesota	51	82.93%	0.81	0.99
Mississippi	45	95.00%	1.76	0.82
Missouri	72	88.26%	1.05	0.89
Montana	10	95.00%	1.27	0.83
Nebraska	21	89.32%	0.96	0.83
Nevada	12	80.28%	0.84	1.25
New Hampshire	11	78.00%	0.55	1.16
New Jersey	89	78.00%	0.58	1.30
New Mexico	19	95.00%	1.51	0.83
New York	234	78.00%	0.93	1.22
North Carolina	89	93.92%	1.05	0.93
North Dakota	9	95.00%	1.18	0.78
Ohio	131	88.25%	0.94	0.92
Oklahoma	46	95.00%	1.29	0.82
Oregon	36	90.39%	1.00	1.01
Pennsylvania	165	83.48%	0.87	1.03
Rhode Island	14	81.64%	0.74	1.16
South Carolina	46	95.00%	1.19	0.90
South Dakota	10	95.00%	1.29	0.78
Tennessee	72	95.00%	1.21	0.91
Texas	204	92.44%	1.32	0.93
Utah	15	95.00%	1.00	0.85
Vermont	7	87.88%	0.84	1.06
Virginia	66	78.00%	0.81	1.03
Washington	51	83.02%	0.86	1.07
West Virginia	30	95.00%	1.46	0.89
Wisconsin	59	88.42%	0.86	0.90
Wyoming	5	95.00%	1.00	0.84

TABLE 15. Percent Distribution by State of Federal Funds Based on Allocation Formula for Home and Community Program for Persons with Severe Disabilities	
	Percent Distribution
Alabama	2.00%
Alaska	0.11%
Arizona	1.47%
Arkansas	1.29%
California	10.33%
Colorado	0.96%
Connecticut	1.29%
Delaware	0.21%
District of Columbia	0.34%
Florida	6.73%
Georgia	2.69%
Hawaii	0.42%
Idaho	0.35%
Illinois	3.95%
Indiana	1.94%
Iowa	1.08%
Kansas	0.89%
Kentucky	1.74%
Louisiana	1.99%
Maine	0.55%
Maryland	1.51%
Massachusetts	2.60%
Michigan	3.28%
Minnesota	1.54%
Mississippi	1.43%
Missouri	2.19%
Montana	0.31%
Nebraska	0.60%
Nevada	0.41%
New Hampshire	0.36%
New Jersey	3.17%
New Mexico	0.59%
New York	8.08%
North Carolina	2.89%
North Dakota	0.25%
Ohio	4.00%
Oklahoma	1.38%
Oregon	1.23%
Pennsylvania	5.29%
Rhode Island	0.46%
South Carolina	1.48%
South Dakota	0.30%
Tennessee	2.34%
Texas	6.84%
Utah	0.45%
Vermont	0.23%
Virginia	1.95%
Washington	1.66%
West Virginia	0.98%
Wisconsin	1.74%
Wyoming	0.13%

3. State Matching Rates

States can draw down these Federal allocations to provide benefits at a match rate that would be 28 percentage points higher than the current Federal Medicaid Assistance Percentage (FMAP) up to a maximum of 95 percent. This means the Federal match rate for benefits will range from 78 percent to 95 percent. Expenditures for administrative functions have differing match rates shown in Table 16.

4. Beneficiary Copayments

Recipients of care are required to pay a portion of their services based on a sliding scale of income as a percent of the poverty level as follows:

Income as a Percent of Poverty	Copayment Percentage
<150%	0%
150-199%	10%
200-249%	20%
250%+	25%

Table 16 provides an analysis of the effect of the coinsurance schedule by age and income group.

TABLE 16. Estimated Coinsurance Expenditures by Participants, 1993

Income as a Percent of Poverty	Copayment Level	Age Less than 65		Age 65 and Over	
		Average Copayment	Percent of Income	Average Copayment	Percent of Income
<150%	0%	$0	0.0%	$0	0.0%
150-149%	0%	$0	0.0%	$0	0.0%
150-199%	10%	$680	5.2%	$1,120	8.6%
200-249%	20%	$1,365	8.1%	$2,240	13.4%
250%+	25%	$1,710	6.4%	$2,800	10.5%

NOTE: Income is based on income of the family unit. Under this definition, adult members not related by marriage are not considered part of the family and are considered separately. For example, a disabled adult living with his or her parents would be counted as a separate unit. For the copayments as a percent of income, the midpoint of the category for a single persons was used in the estimates.

5. Administrative Costs

Table 17 provides the data on the administrative costs assumed for the new program-in each fiscal year.

TABLE 17. Fiscal Year Estimates of Administrative Expenditures Under Program								
	1996	1997	1998	1999	2000	2001	2002	2003
Screening and Assessment	$427	$525	$647	$796	$980	$1,023	$1,068	$1,116
Federal Share %	90%	90%	90%	90%	90%	90%	90%	90%
Federal Share $	$384	$473	$582	$716	$882	$921	$962	$1,004
State Share $	$43	$53	$65	$80	$98	$102	$107	$112
Other	$526	$759	$872	$1,003	$1,104	$1,527	$1,980	$2,187
Ongoing Administration	$342	$531	$654	$802	$938	$1,298	$1,683	$1,859
Federal Share %	50%	50%	50%	50%	50%	50%	50%	50%
Federal Share $	$171	$266	$327	$401	$469	$649	$842	$929
State Share $	$171	$266	$327	$401	$469	$649	$842	$929
Claims Automation	$184	$228	$218	$201	$166	$229	$297	$328
Federal Share %	90%	90%	90%	90%	90%	90%	90%	75%
Federal Share $	$166	$205	$196	$180	$149	$206	$267	$246
State Share $	$18	$23	$22	$20	$17	$23	$30	$82
TOTAL FEDERAL	$721	$943	$1,105	$1,298	$1,500	$1,776	$2,070	$2,180
TOTAL STATE	$232	$341	$413	$501	$584	$774	$978	$1,123
TOTAL	$953	$1,284	$1,518	$1,799	$2,083	$2,550	$3,048	$3,303

To estimate administrative costs we made the following assumptions:

- Telephone screening would be conducted for 3.1 million persons in 1996 at a cost of $25 per person in 1993 dollars. We assumed that the number of persons screened would increase to 6.9 million once the program was fully phased-in. The estimate of the number of persons screened under the fully phased-in program was based on an assumption that in addition to those eligible to the program, a similar number of persons would be screened and found not eligible based on the disability criteria.

- Full assessments would be conducted and care plans developed for 1.4 million persons in 1996 (one-half of the expected 78 percent of eligibles) at a cost of $225 per person in 1993 dollars. The participation rate of 78 percent is based on the resulting participation rate assuming 100 percent induced demand over current use of paid services among persons who would be eligible for the program. We assumed that the number of persons receiving full assessment screened would increase to 3.0 million once the program was fully phased-in.

- As shown above, assessment and screening costs in FY 1996 were assumed to be 50 percent (in real terms) of the estimated total amount when the program is fully phased-in. This amount was increased each year, reaching 100 percent by FY 2000. We assumed less than 100 percent of the estimated assessment and screening costs in the early years of the program to reflect the necessary start-up period for the program to become fully implemented.

- Other administrative costs of the program (e.g., contracting, quality assurance, and fraud and abuse investigations), are estimated to be 7 percent of benefits in FY 1996, 6 percent in FY 1997, 5 percent in FY 1998, 4.5 percent in FY 1999, and 4 percent in FY 2000. An estimate of four percent of total expenditures for administrative costs other than assessment and screenings is consistent with the current Medicaid program where all administrative functions account for less than four percent of total expenditures.

- Claims administration costs would make up a declining percentage of other administrative costs--35 percent in FY 1996, 30 percent in FY 1997, 25 percent in FY 1998, 20 percent in FY 1999, and 15 percent in FY 2000.

- Care planning costs are included in the benefit expenditures estimates.

The Federal matching percentage for administrative costs was designed to assist States in establishing claims processing and client tracking systems and to carry out eligibility determinations and assessments with higher match rates. For most States the 90 percent match rate is higher than the benefit match rate. For the States with the lowest per capita income that receive a Federal benefit match rate of 95 percent, the 90 percent administrative cost match rate is lower than the benefit match rate. The lower 50 percent match rate on other administrative functions was designed to encourage benefit payments over administrative functions.

The 10 percent limit once the program is fully phased-in guarantees that administrative functions will also be small relative to benefit payments.

E. State Impact

States have an important role in the administration of the program. States are responsible for eligibility determination, care planning, resource allocation, ongoing case management, utilization review, and ensuring the quality of care under Federal guidelines. States may contract with others to perform these services, but States have responsibility for the actions of these contractors. States must submit to the Secretary of Health and Human Services a long-term care plan for approval.

All States have available increased Federal funding for home and community-based services at a low match rate (relative to the Medicaid program). Many States will be able to fully fund the new program for all program participants without spending any more than they already do through Medicaid for the severely disabled. States with very low home and community-based expenditures currently would have to increase their expenditures to fully fund the program.

In estimating the expenditures under the program and the impact on States, we have assumed that all States match their full Federal allocation in all years. This may overestimate the level of expenditures under the program because some States may chose not to spend the entire allocated amount.

1. Continuing Medicaid Program

It is difficult to project how the new program will interact with the continuing Medicaid program. In modeling the impact of the program, we have assumed that States would continue to serve persons who would not be eligible for the program at the

same level as they currently serve these persons. This seems reasonable because many States will be able to implement the new program without significant increases over current projected expenditures.

2. Estimates of State Impact

Under the allocation formula, each State will receive Federal funds that they can match. Tables 18 through 21 present relevant data on Federal funds. Table 18 presents the amounts of new Federal funds by State and fiscal year. Table 19 presents projected baseline Medicaid home and community-based expenditures, and Table 20 presents the estimated portion of these expenditures (50 percent) which are assumed to go for persons with severe disabilities. These Medicaid expenditures are based on the national expenditures projections developed by the HCFA actuaries.[10] Table 21 presents the total amounts of Federal funds which are estimated to go to the States under the new program. This includes the amounts of new Federal funds and amounts of Medicaid funds which are expected to be transferred to the new program.

Although the States have great incentives to transfer as many Medicaid recipients to the new program as meet the functional eligibility criteria, the States also have an obligation to serve persons of all incomes under the new program. For purposes of illustration, Table 21 assumes that no State may spend more that 75 percent of its new Federal program funds during the phase-in on persons who would have otherwise been eligible to receive home and community-based services under the Medicaid program. Applying this rule for purposes of estimating the State impact, the Federal expenditures that would have been spent for Medicaid recipients become the Federal Medicaid offset. The Federal Medicaid offset is added to the new Federal funds available which results in the total Federal funds available under the program. To ensure that Medicaid recipients are served under the new program or under the continuing Medicaid program, we applied a second decision rule, for purposes of estimating State impact, that no more than 75 percent of the new Federal funds plus the amount allocated to a State for the Medicaid refinancing, plus the corresponding State match for these funds, could be used for persons who would have otherwise received Medicaid home and community-based services. If total current law Medicaid expenditures in a State for persons with severe disabilities exceeds the allowed amount under the new program for "former" Medicaid recipients, the State is assumed to provide services to these individuals under the continuing Medicaid program.

Table 22 presents the projected current law State expenditures for persons with severe disabilities by State and fiscal year. These State expenditures include one-half of projected State Medicaid HCBS expenditures plus State-only funds for persons with severe disabilities.

[10] The HCFA projections of Medicaid expenditures for pesonal care, home health, home and community-based waivers, CSLA, and the frail elderly were used. All States were assumed to have the same rate of growth in expenditures from 1992 forward.

TABLE 18. New Federal Funds Available to States Under Home and Community-Based Services Program for Persons with Severe Disabilities by Fiscal Year (in millions of nominal dollars)								
	1996	1997	1998	1999	2000	2001	2002	2003
United States	$4,500	$7,800	$11,000	$14,700	$18,700	$26,700	$35,500	$38,300
Alabama	$90	$156	$220	$294	$374	$534	$710	$767
Alaska	$5	$8	$12	$16	$20	$28	$38	$41
Arizona	$66	$115	$162	$216	$275	$393	$522	$563
Arkansas	$58	$100	$142	$189	$241	$343	$457	$493
California	$465	$806	$1,136	$1,519	$1,932	$2,758	$3,667	$3,957
Colorado	$43	$75	$106	$142	$180	$257	$342	$369
Connecticut	$58	$101	$142	$189	$241	$344	$458	$494
Delaware	$9	$16	$23	$30	$38	$55	$73	$79
District of Columbia	$15	$26	$37	$50	$63	$90	$120	$130
Florida	$303	$525	$740	$989	$1,259	$1,797	$2,389	$2,578
Georgia	$121	$210	$296	$395	$503	$718	$955	$1,030
Hawaii	$19	$33	$46	$62	$78	$112	$149	$160
Idaho	$16	$27	$38	$51	$65	$93	$124	$134
Illinois	$178	$308	$434	$580	$738	$1,053	$1,401	$1,511
Indiana	$87	$152	$214	$286	$363	$519	$690	$744
Iowa	$49	$84	$119	$159	$203	$289	$385	$415
Kansas	$40	$69	$98	$131	$167	$238	$316	$341
Kentucky	$78	$136	$192	$256	$326	$465	$619	$668
Louisiana	$90	$155	$219	$293	$373	$532	$708	$763
Maine	$25	$43	$61	$81	$103	$147	$195	$211
Maryland	$68	$118	$166	$222	$282	$403	$536	$578
Massachusetts	$117	$203	$286	$383	$487	$695	$924	$997
Michigan	$147	$256	$360	$482	$613	$875	$1,163	$1,255
Minnesota	$69	$120	$170	$227	$288	$412	$547	$590
Mississippi	$65	$112	$158	$211	$268	$383	$509	$549
Missouri	$98	$171	$241	$322	$409	$584	$776	$838
Montana	$14	$25	$35	$46	$59	$84	$112	$120
Nebraska	$27	$47	$66	$89	$113	$161	$214	$231
Nevada	$18	$32	$45	$60	$77	$109	$145	$157
New Hampshire	$16	$28	$39	$53	$67	$95	$127	$137
New Jersey	$143	$247	$349	$466	$593	$846	$1,125	$1,214
New Mexico	$27	$46	$65	$87	$111	$158	$210	$227
New York	$364	$630	$889	$1,188	$1,511	$2,158	$2,869	$3,096
North Carolina	$130	$226	$318	$425	$541	$773	$1,027	$1,108
North Dakota	$11	$20	$28	$37	$48	$68	$90	$97
Ohio	$180	$312	$440	$587	$747	$1,067	$1,418	$1,530
Oklahoma	$62	$108	$152	$203	$258	$368	$490	$528
Oregon	$55	$96	$135	$181	$230	$328	$436	$470
Pennsylvania	$238	$413	$582	$778	$990	$1,413	$1,879	$2,027
Rhode Island	$21	$36	$50	$67	$86	$122	$163	$176
South Carolina	$67	$115	$163	$217	$276	$395	$525	$566
South Dakota	$14	$24	$33	$44	$56	$81	$107	$116
Tennessee	$105	$183	$258	$344	$438	$626	$832	$897
Texas	$308	$533	$752	$1,005	$1,279	$1,826	$2,428	$2,619
Utah	$20	$35	$49	$65	$83	$119	$158	$171
Vermont	$10	$18	$25	$33	$42	$60	$80	$86
Virginia	$88	$152	$214	$286	$364	$519	$691	$745
Washington	$75	$129	$182	$244	$310	$442	$588	$635
West Virginia	$44	$76	$108	$144	$183	$262	$348	$376
Wisconsin	$78	$136	$191	$256	$325	$464	$617	$666
Wyoming	$6	$11	$15	$20	$25	$36	$48	$52

TABLE 19. Total Current Law Federal Medicaid Home and Community-Based Services Expenditures by Fiscal Year (in millions of nominal dollars)								
	1996	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**
United States	$6,382	$7,200	$7,818	$8,796	$9,613	$10,650	$11,798	$13,071
Alabama	$76	$86	$94	$105	$115	$127	$141	$156
Alaska	$2	$2	$2	$2	$3	$3	$3	$4
Arizona	$1	$1	$1	$1	$1	$1	$2	$2
Arkansas	$82	$93	$101	$113	$124	$137	$152	$168
California	$50	$56	$61	$68	$75	$83	$92	$101
Colorado	$88	$99	$107	$121	$132	$146	$162	$179
Connecticut	$184	$208	$226	$254	$277	$307	$340	$377
Delaware	$17	$19	$20	$23	$25	$28	$31	$34
District of Columbia	$13	$15	$16	$18	$20	$22	$24	$27
Florida	$104	$118	$128	$144	$157	$174	$193	$214
Georgia	$98	$111	$121	$136	$148	$164	$182	$202
Hawaii	$11	$12	$13	$15	$16	$18	$19	$22
Idaho	$21	$23	$25	$29	$31	$35	$38	$42
Illinois	$124	$140	$152	$171	$187	$207	$230	$255
Indiana	$47	$53	$57	$64	$70	$78	$86	$95
Iowa	$21	$24	$26	$30	$32	$36	$40	$44
Kansas	$36	$41	$44	$50	$55	$61	$67	$74
Kentucky	$125	$140	$153	$172	$188	$208	$230	$255
Louisiana	$27	$31	$33	$37	$41	$45	$50	$56
Maine	$47	$53	$57	$64	$70	$78	$86	$96
Maryland	$121	$137	$149	$167	$183	$203	$225	$249
Massachusetts	$274	$309	$336	$378	$413	$458	$507	$562
Michigan	$217	$244	$265	$298	$326	$361	$400	$443
Minnesota	$205	$231	$251	$283	$309	$342	$379	$420
Mississippi	$12	$13	$14	$16	$18	$20	$22	$24
Missouri	$103	$117	$127	$142	$156	$172	$191	$212
Montana	$36	$40	$44	$49	$54	$59	$66	$73
Nebraska	$45	$50	$55	$62	$67	$75	$83	$92
Nevada	$10	$12	$13	$14	$16	$17	$19	$21
New Hampshire	$56	$63	$68	$77	$84	$93	$103	$114
New Jersey	$236	$267	$290	$326	$356	$394	$437	$484
New Mexico	$35	$40	$43	$49	$53	$59	$65	$72
New York	$2,123	$2,395	$2,600	$2,925	$3,197	$3,542	$3,924	$4,347
North Carolina	$165	$187	$203	$228	$249	$276	$306	$339
North Dakota	$33	$38	$41	$46	$50	$56	$62	$68
Ohio	$82	$92	$100	$113	$123	$136	$151	$167
Oklahoma	$83	$94	$102	$114	$125	$138	$153	$170
Oregon	$162	$183	$198	$223	$244	$270	$299	$331
Pennsylvania	$197	$222	$241	$271	$297	$329	$364	$403
Rhode Island	$60	$68	$74	$83	$91	$101	$112	$124
South Carolina	$52	$59	$64	$72	$78	$87	$96	$107
South Dakota	$28	$32	$34	$39	$42	$47	$52	$57
Tennessee	$64	$72	$78	$88	$96	$106	$118	$130
Texas	$205	$231	$251	$283	$309	$342	$379	$420
Utah	$45	$50	$55	$62	$67	$75	$83	$92
Vermont	$32	$36	$39	$44	$48	$53	$58	$65
Virginia	$68	$77	$83	$94	$102	$113	$126	$139
Washington	$141	$159	$173	$195	$213	$236	$261	$290
West Virginia	$98	$110	$120	$135	$147	$163	$181	$200
Wisconsin	$205	$232	$252	$283	$309	$343	$380	$421
Wyoming	$16	$18	$19	$22	$24	$26	$29	$32
NOTE: Current law for Medicaid as estimated by the Health Care Financing Administration (HCFA) Office of the Actuary for the President's FY 1995 budget.								

TABLE 20. Current Law Federal Medicaid Home and Community-Based Service Expenditures for Persons with Severe Disabilities by Fiscal Year (in millions of nominal dollars)								
	1996	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**
United States	$3,191	$3,600	$3,909	$4,398	$4,807	$5,325	$5,899	$6,535
Alabama	$38	$43	$47	$53	$57	$64	$71	$78
Alaska	$1	$1	$1	$1	$1	$1	$2	$2
Arizona	$0	$0	$1	$1	$1	$1	$1	$1
Arkansas	$41	$46	$50	$57	$62	$68	$76	$84
California	$25	$28	$30	$34	$37	$41	$46	$51
Colorado	$44	$49	$54	$60	$66	$73	$81	$90
Connecticut	$92	$104	$113	$127	$139	$154	$170	$189
Delaware	$8	$9	$10	$12	$13	$14	$15	$17
District of Columbia	$7	$7	$8	$9	$10	$11	$12	$14
Florida	$52	$59	$64	$72	$79	$87	$96	$107
Georgia	$49	$56	$60	$68	$74	$82	$91	$101
Hawaii	$5	$6	$6	$7	$8	$9	$10	$11
Idaho	$10	$12	$13	$14	$16	$17	$19	$21
Illinois	$62	$70	$76	$86	$94	$104	$115	$127
Indiana	$23	$26	$29	$32	$35	$39	$43	$48
Iowa	$11	$12	$13	$15	$16	$18	$20	$22
Kansas	$18	$20	$22	$25	$27	$30	$34	$37
Kentucky	$62	$70	$76	$86	$94	$104	$115	$127
Louisiana	$14	$15	$17	$19	$20	$23	$25	$28
Maine	$23	$26	$29	$32	$35	$39	$43	$48
Maryland	$61	$69	$74	$84	$91	$101	$112	$124
Massachusetts	$137	$155	$168	$189	$207	$229	$254	$281
Michigan	$108	$122	$133	$149	$163	$181	$200	$222
Minnesota	$103	$116	$126	$141	$154	$171	$190	$210
Mississippi	$6	$7	$7	$8	$9	$10	$11	$12
Missouri	$52	$58	$63	$71	$78	$86	$96	$106
Montana	$18	$20	$22	$24	$27	$30	$33	$36
Nebraska	$22	$25	$27	$31	$34	$37	$41	$46
Nevada	$5	$6	$6	$7	$8	$9	$10	$11
New Hampshire	$28	$31	$34	$38	$42	$46	$51	$57
New Jersey	$118	$133	$145	$163	$178	$197	$218	$242
New Mexico	$18	$20	$22	$24	$27	$29	$33	$36
New York	$1,061	$1,197	$1,300	$1,463	$1,599	$1,771	$1,962	$2,174
North Carolina	$83	$93	$101	$114	$125	$138	$153	$169
North Dakota	$17	$19	$20	$23	$25	$28	$31	$34
Ohio	$41	$46	$50	$56	$62	$68	$76	$84
Oklahoma	$41	$47	$51	$57	$62	$69	$77	$85
Oregon	$81	$91	$99	$111	$122	$135	$150	$166
Pennsylvania	$98	$111	$121	$136	$148	$164	$182	$202
Rhode Island	$30	$34	$37	$42	$46	$50	$56	$62
South Carolina	$26	$29	$32	$36	$39	$43	$48	$53
South Dakota	$14	$16	$17	$19	$21	$23	$26	$29
Tennessee	$32	$36	$39	$44	$48	$53	$59	$65
Texas	$103	$116	$126	$141	$154	$171	$190	$210
Utah	$22	$25	$27	$31	$34	$37	$41	$46
Vermont	$16	$18	$19	$22	$24	$26	$29	$32
Virginia	$34	$38	$42	$47	$51	$57	$63	$70
Washington	$71	$80	$87	$97	$106	$118	$131	$145
West Virginia	$49	$55	$60	$67	$74	$82	$90	$100
Wisconsin	$103	$116	$126	$142	$155	$171	$190	$210
Wyoming	$8	$9	$10	$11	$12	$13	$14	$16
NOTE: Current law for Medicaid as estimated by the Health Care Financing Administration (HCFA) Office of the Actuary for the President's FY 1995 budget.								

TABLE 21. Total Federal Funds Available to States Under New Home and Community-Based Service Program by Fiscal Year (New Federal + Medicaid)* (in millions of nominal dollars)								
	1996	1997	1998	1999	2000	2001	2002	2003
United States	$5,929	$10,111	$13,819	$18,080	$22,582	$31,291	$40,817	$44,150
Alabama	$119	$202	$277	$362	$452	$626	$817	$884
Alaska	$6	$11	$15	$19	$24	$33	$43	$47
Arizona	$87	$149	$203	$266	$332	$460	$600	$649
Arkansas	$76	$130	$178	$233	$291	$403	$525	$568
California	$613	$1,045	$1,428	$1,868	$2,333	$3,233	$4,217	$4,561
Colorado	$57	$97	$133	$174	$218	$301	$393	$425
Connecticut	$76	$130	$178	$233	$291	$403	$526	$569
Delaware	$12	$21	$28	$37	$46	$64	$84	$91
District of Columbia	$20	$34	$47	$61	$76	$106	$138	$149
Florida	$399	$681	$930	$1,217	$1,520	$2,106	$2,747	$2,971
Georgia	$159	$272	$372	$486	$607	$841	$1,098	$1,187
Hawaii	$25	$42	$58	$76	$95	$131	$171	$185
Idaho	$21	$35	$48	$63	$79	$109	$142	$154
Illinois	$234	$399	$545	$713	$891	$1,234	$1,610	$1,742
Indiana	$115	$197	$269	$351	$439	$608	$793	$858
Iowa	$64	$110	$150	$196	$245	$339	$442	$478
Kansas	$53	$90	$123	$161	$201	$279	$364	$393
Kentucky	$103	$176	$241	$315	$394	$546	$712	$770
Louisiana	$118	$202	$275	$360	$450	$624	$814	$880
Maine	$33	$56	$76	$99	$124	$172	$225	$243
Maryland	$89	$153	$208	$273	$341	$472	$616	$666
Massachusetts	$154	$263	$360	$471	$588	$815	$1,063	$1,150
Michigan	$194	$331	$453	$592	$740	$1,025	$1,337	$1,446
Minnesota	$91	$156	$213	$279	$348	$482	$629	$680
Mississippi	$85	$145	$198	$259	$324	$449	$585	$633
Missouri	$130	$221	$302	$395	$494	$684	$893	$966
Montana	$19	$32	$43	$57	$71	$98	$128	$139
Nebraska	$36	$61	$83	$109	$136	$189	$247	$267
Nevada	$24	$41	$57	$74	$92	$128	$167	$181
New Hampshire	$21	$36	$49	$65	$81	$112	$146	$158
New Jersey	$188	$320	$438	$573	$716	$992	$1,294	$1,399
New Mexico	$35	$60	$82	$107	$134	$186	$242	$262
New York	$479	$817	$1,117	$1,461	$1,825	$2,529	$3,299	$3,568
North Carolina	$172	$293	$400	$523	$654	$906	$1,181	$1,278
North Dakota	$15	$26	$35	$46	$57	$80	$104	$112
Ohio	$237	$404	$552	$722	$902	$1,250	$1,631	$1,764
Oklahoma	$82	$140	$191	$249	$312	$432	$563	$609
Oregon	$73	$124	$170	$222	$277	$384	$501	$542
Pennsylvania	$314	$535	$731	$957	$1,195	$1,656	$2,161	$2,337
Rhode Island	$27	$46	$63	$83	$104	$143	$187	$202
South Carolina	$88	$149	$204	$267	$334	$462	$603	$652
South Dakota	$18	$31	$42	$55	$68	$94	$123	$133
Tennessee	$139	$237	$324	$424	$529	$733	$956	$1,034
Texas	$405	$691	$945	$1,236	$1,544	$2,140	$2,791	$3,019
Utah	$26	$45	$62	$80	$101	$139	$182	$197
Vermont	$13	$23	$31	$41	$51	$71	$92	$100
Virginia	$115	$197	$269	$352	$439	$609	$794	$859
Washington	$98	$168	$229	$300	$374	$518	$676	$731
West Virginia	$58	$99	$136	$177	$221	$307	$400	$433
Wisconsin	$103	$176	$240	$314	$393	$544	$710	$768
Wyoming	$8	$14	$19	$24	$30	$42	$55	$60

* Assumes no State may spend more than 75 percent of its allocation during the phase-in on Medicaid eligibles. The Medicaid offset estimate reflects more recent data that were not available at the time the President's FY95 Budget was prepared.

TABLE 22. Current Law State Medicaid and State-Only Home and Community-Based Service Expenditures for Persons with Severe Disabilities by Fiscal Year (in millions of nominal dollars)								
	1996	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**
United States	$4,337	$4,766	$5,134	$5,631	$6,039	$6,527	$7,060	$7,641
Alabama	$26	$28	$30	$33	$36	$39	$42	$45
Alaska	$6	$6	$7	$7	$8	$8	$8	$9
Arizona	$27	$28	$30	$32	$33	$34	$35	$36
Arkansas	$20	$22	$23	$26	$28	$30	$33	$36
California	$428	$454	$483	$510	$531	$550	$570	$590
Colorado	$50	$56	$60	$67	$72	$79	$86	$94
Connecticut	$165	$181	$195	$213	$228	$246	$265	$286
Delaware	$11	$13	$14	$15	$16	$18	$19	$21
District of Columbia	$9	$10	$11	$12	$13	$14	$15	$17
Florida	$90	$98	$105	$115	$122	$131	$140	$150
Georgia	$62	$68	$73	$80	$85	$91	$98	$105
Hawaii	$10	$11	$12	$13	$14	$15	$16	$17
Idaho	$8	$9	$9	$10	$11	$12	$12	$13
Illinois	$114	$125	$135	$147	$157	$169	$182	$197
Indiana	$38	$41	$44	$48	$51	$54	$57	$61
Iowa	$42	$45	$48	$51	$54	$56	$59	$61
Kansas	$28	$30	$32	$35	$37	$40	$43	$46
Kentucky	$30	$33	$36	$40	$43	$48	$52	$57
Louisiana	$15	$16	$17	$18	$19	$21	$22	$23
Maine	$20	$22	$23	$26	$28	$31	$33	$36
Maryland	$97	$107	$115	$126	$136	$147	$159	$173
Massachusetts	$219	$241	$260	$286	$307	$332	$360	$391
Michigan	$146	$161	$173	$189	$203	$219	$237	$256
Minnesota	$116	$129	$139	$154	$166	$181	$197	$215
Mississippi	$16	$17	$18	$19	$20	$21	$22	$22
Missouri	$65	$71	$76	$83	$89	$95	$103	$111
Montana	$13	$14	$15	$17	$18	$20	$21	$23
Nebraska	$24	$26	$28	$31	$33	$36	$39	$42
Nevada	$12	$13	$14	$15	$16	$17	$18	$19
New Hampshire	$35	$39	$42	$47	$51	$55	$61	$66
New Jersey	$178	$196	$212	$233	$251	$272	$296	$322
New Mexico	$13	$14	$15	$17	$18	$19	$21	$22
New York	$1,199	$1,342	$1,454	$1,625	$1,767	$1,944	$2,140	$2,357
North Carolina	$74	$82	$88	$96	$103	$111	$120	$130
North Dakota	$10	$11	$12	$13	$14	$16	$17	$18
Ohio	$138	$148	$158	$169	$177	$186	$195	$204
Oklahoma	$40	$43	$47	$51	$54	$58	$62	$66
Oregon	$61	$68	$73	$81	$88	$97	$106	$116
Pennsylvania	$165	$180	$193	$210	$224	$240	$258	$277
Rhode Island	$32	$36	$39	$43	$46	$51	$56	$61
South Carolina	$22	$24	$26	$28	$30	$32	$34	$37
South Dakota	$8	$9	$10	$11	$12	$13	$14	$15
Tennessee	$26	$29	$31	$34	$36	$39	$42	$46
Texas	$137	$149	$160	$173	$184	$196	$209	$223
Utah	$11	$12	$13	$14	$15	$16	$18	$19
Vermont	$13	$14	$15	$17	$19	$20	$22	$25
Virginia	$59	$65	$70	$76	$82	$88	$95	$103
Washington	$74	$82	$89	$99	$107	$117	$128	$140
West Virginia	$20	$22	$24	$26	$28	$31	$34	$37
Wisconsin	$104	$114	$123	$136	$146	$158	$172	$187
Wyoming	$11	$12	$13	$14	$15	$16	$17	$18
NOTE: Current law for Medicaid as estimated by the Health Care Financing Administration (HCFA) Office of the Actuary for the President's FY 1995 budget.								

IV. MEDICAID INSTITUTIONAL CHANGES

The Medicaid institutional care changes include:

- All States must use a medically needy standard for determining eligibility. That is, medical expenses must be subtracted from income in determining eligibility for Medicaid coverage in an institution.

- The monthly personal needs allowance increases from a minimum of $30 to $50. The Federal Government will pay 100 percent of the difference between the increase in the personal needs allowance and the rate in effect in a particular State on September 30, 1993. The personal needs allowance permits Medicaid nursing facility and ICF-MR residents to purchase personal items not otherwise covered by Medicaid reimbursement, such as clothing, television, reading material and cosmetics.

- States have the option to increase the financial resource limit from $2,000 to $12,000 for unmarried individuals in institutions.

The estimated change in Medicaid expenditures were based on results from the Brooking-ICF Long-Term Care Financing Model. They assume that States constituting one-third of the nursing home population would elect to increase the Medicaid asset limit for individuals.

V. FEDERAL TAX INCENTIVES AND LONG-TERM CARE INSURANCE REGULATION

A. Federal Tax Incentives

The Health Security Act also includes Federal tax incentives related to long-term care. The Act:

- Permits individuals to deduct payments for long-term care services and premiums under the individual income tax medical expense deduction.

- Excludes long-term care insurance premiums paid by an employer from taxable income for the purchase of long-term care insurance.

- Excludes claims payments made by insurance policies for accelerated death benefits from taxable income.

- Provides a tax credit for personal assistance services required by employed individuals with disabilities.

B. Federal Standards for Private Long-term Care Insurance Regulations

Finally, the Health Security Act provides for Federal standards for the regulation of private long- term care insurance, grants to aid States in enforcing these standards, and grants for consumer education about long-term care insurance. The regulations will be promulgated by the Secretary of Health and Human Services with the advice and assistance of a newly created National Long- Term Care Insurance Advisory Council. The National Long-Term Care Insurance Advisory Council will also collect, analyze, and disseminate information, as well as monitor the development of the private long-term care insurance market.

The Act calls for the following regulatory provisions:

- uniform terms, definitions and format for policies;

- standard outlines of coverage;

- the Secretary will consider limits on annual premium increases;

- development of standard eligibility criteria or threshold conditions;

- require that inflation protection for benefit payments be offered as an option in all policies;

- require that all policies include non-forfeiture benefits as defined by the Secretary; and

- provisions that include civil monetary penalties for abuses in the sale and marketing of long-term care insurance.

C. Revenue Estimating Methodology

The Department of the Treasury developed estimates of the tax revenue effects of the alternative proposals described above. These estimates are summarized in Table 23.

TABLE 23. Summary of Revenue Estimates (amounts in millions)

	Effective Date	FY 1994	FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 1994-2000
Qualified Long-Term Care	1/1/96	0	0	-58	-172	-179	-186	-194	-789
Long-Term Care Insurance	1/1/96	0	0	-87	-249	-341	-437	-532	-1,646
Accelerated Death Benefits	1/1/94	-1	-3	-3	-4	-5	-6	-7	-29
Credit for Cost of PAS	1/1/96	0	0	-23	-118	-125	-134	-143	-543
Total		-1	-3	-171	-543	-650	-763	-876	-3,007

1. Qualified Long-Term Care Expenses

Under current law, certain long-term care expenses are not tax deductible. Under the proposal, qualified long-term care expenses will be treated as tax deductible medical expenses. Long-term care expenses considered here are out-of-pocket expenditures for both home and community- based services and institutional care.

The revenue estimates for qualified long-term care expenses are based on three major steps. First, the 1987 NNMS data were used to estimate qualified out-of-pocket home care expenses under the proposal. The qualified expenses were projected to the year 2000 by using the growth in the population over age 65 and the Consumer Price Index. Second, projections of out-of- pocket nursing home expenses to the year 2000 from HCFA were used to estimate qualified institutional care expenses. Finally, the effective tax rate for those individuals with qualified long-term care expenses was derived from the Treasury Individual Tax Model and applied to the qualified expenses to estimate the revenue effect of the proposal.

2. Long-Term Care Insurance

Under the proposal, qualified long-term care insurance policies would receive several favorable tax treatments. Specifically, premiums paid by individuals for qualified policies would be tax deductible as medical expenses, and premiums paid by employers in a qualified group plan would be excluded from an employee's income for income tax and employment tax purposes. In addition, benefits received from a qualified long-term care insurance policy would be excluded from the recipient's income, up to $150 per day.

The projections of premiums paid and benefits received from qualified long-term care insurance policies under current law and proposed law used by Treasury to estimate the impact of these proposals were provided by the Department of Health and Human Services (DHHS). These projections were based on simulation results from the Brookings-ICF Long-Term Care Financing Model. The projections for proposed law incorporate the effect of increased demand for long- term care insurance policies due to lower out-of-pocket expenses that would result from the favorable tax treatments. The Treasury Individual Tax Model was then used to derive the effective tax rates applicable to purchaser and benefit recipients of long-term care insurance policies.

In order to develop estimates of long-term care insurance purchase, premiums, and benefit payments under current policy and the provision of the Health Security Act, we needed to incorporate the current level of long-term care insurance, its expected role in financing care, and develop estimates of its expected growth. Modeling long-term care insurance requires assumptions about the types of policies available, the probability of purchase, the likelihood that purchasers will lapse policies, and the induced demand of purchasers. In modeling the long-term care insurance market, we tried to reflect the diversity of the market. To do this, we assumed individuals who purchased insurance would buy either a two-year or a four-year long-term care insurance policy. The shorter policy reflects many of the less-expensive policies on the market while the longer policy reflects the more expensive policies. We assumed that individuals who decided to buy insurance would buy the four-year policy if they could afford it. If an individual who was simulated to buy insurance was unable to afford the four-year policy, we assumed he or she would purchase the two-year policy. The long-term care policies used in the model had the following features:

Payment Rates (in 1986 dollars):

- Nursing Facility--$60
- Home Care--$30

Deductible Period:

- Nursing Facility--60 days

- Home Care--30 visits

- Eligibility--for home care, two or more ADLs or a similar level of cognitive impairment

- Indexing--benefits increase 5.5 percent compounded annually

- Premiums--Premiums are assumed to increase 5.5 percent annually until age 65 and then become level thereafter. The premiums shown in the Table 24 were based on the fair market premium estimated by the Brookings-ICF model with adjustments for lapse assumptions and administrative markup.

TABLE 24. Annual Long-Term Care Insurance Premiums for Selected Ages, 1986

Age	Individual		Group	
	Two Year	Four Year	Two Year	Four Year
40	$239	$343	$209	$301
45	315	452	275	397
50	416	597	363	524
55	585	840	511	734
60	839	1,235	751	1,079
65	1,333	1,923	1,166	1,682
70	1,893	2,752	1,657	2,408
75	2,322	3,408	2,031	2,974
80	2,689	4,039	2,401	3,524

SOURCE: Brookings Institution estimates based on the fair market value of benefits simulated by the Brookings-ICF Long-Term Care Financing Model.

To model the probability of purchasing long-term care insurance, we analyzed trends in the rate of growth in the number of policies sold over the past seven years.[11] Based on this analysis, we developed purchase probabilities that produce approximately the number of policies in force currently.[12] Because there are very little data on the characteristics of purchasers of long-term care insurance and the rate of purchase among different demographic groups, the assumptions used rely heavily on the premise that the likelihood of purchasing long-term care insurance is related to the level of financial resources. The purchase assumptions shown in Table 25 below reflect an inverse relationship between the probability of purchase and the premium as a percentage of the potential purchaser's income. For working-age persons, we assumed that employers would slowly introduce long-term care insurance as an employee benefit. We assumed that these group policies would have somewhat lower premiums and that employees would pay the entire premium. We assumed that an additional 2.5 percent of employees whose employers sponsored pension benefit plans would be offered long-term care insurance policies each year, up to a total of 50 percent in 2020.

[11] The Brookings-ICF model starts to simulate expenditures in 1986. Thus, the model simulates historical periods.

[12] We estimate that them are between 1.5 and 2.0 million long-term cart policies in force in 1993. This estimate is based on information from the Health Insurance Association of America that as of the end of 1991, 2.4 million long-term care insurance policies had been sold. Based on the growth in sales of long-term care policies in recent years and reported lapse rates of 20-40 percent, we estimate that in 1993 between 1.5 and 2.0 million policies are in force.

TABLE 25. Probability of Purchase of Long-Term Care Insurance Assumptions, by Age and Premium as a Percent of Income				
Premium as a Percent of Income	**Age**			
	<49	**50-59**	**60-64**	**65+**
Greater than 5.0%	0%	0%	0%	0%
4.0-5.0%	0%	0%	0%	2%
3.5-4.0%	0%	0%	5%	3%
3.0-3.5%	0%	0%	5%	3%
2.5-3.0%	0%	5%	5%	4%
2.0-2.5%	0%	5%	10%	4%
1.5-2.0%	5%	10%	15%	5%
1.0-1.5%	10%	15%	20%	5%
Less than 1.0%	15%	20%	25%	5%
NOTE: We assumed that only persons age 65 and older who had $10,000 or more in financial assets would purchase insurance.				

The lapse assumptions shown in Table 26 assume that the older a purchaser becomes, the more likely he or she is to spend more on the policy.

TABLE 26. Lapse Assumptions	
Age	**Lapse Point: Premium as a Percent of Income**
45-49	Exceeds 4 percent of income
50-59	Exceeds 5 percent of income
60-64	Exceeds 6 percent of income
65-69	Exceeds 7 percent of income
70 and over	Exceeds 8 percent of income

Finally, we assumed that there would be induced demand among purchasers of long-term care insurance due to the lower out-of-pocket spending incurred under the policy (see the end of the appendix for a discussion of induced demand). The induced demand assumptions we used are as follows:

Nursing Facility:

- Two Year Policy--15 percent
- Four Year Policy--20 percent

Home Care--80 percent

To estimate the effect of employer deductibility of premiums on the purchase of long-term care insurance policies, the probability of purchase among those purchasing through employer plans was increased. To estimate the effect of higher purchase rates as a result of more widespread offering of insurance due to making premiums deductible by employers, the purchase rates were increased 25 percent. The result is the estimates of the total number of policyholders (in millions) in selected years shown in Table 27.

TABLE 27. Number of Long-Term Care Insurance Policyholders		
Year	Current Policy	Employer Deduction
1993	1.8	1.8
2000	7.6	9.3
2010	18.0	21.5

Table 28 and Table 29 provide the corresponding estimates of the amount paid in long-term care insurance premiums and insurance benefits under current law assumptions and employer deductibility.

TABLE 28. Long-Term Care Insurance Premiums Paid (in billions of 1992 dollars)		
Year	Current Policy	Employer Deduction
1993	$2.4	$2.4
2000	7.3	8.7
2010	17.3	20.1

Average premiums paid over time decline under these purchase assumptions as more younger purchasers buy policies.

TABLE 29. Long-Term Care Insurance Benefits Paid for the Elderly (in billions of 1992 dollars)		
Year	Current Policy	Employer Deduction
1993	$0.2	$0.2
2000	1.0	1.0
3.4	3.6	21.5

3. Tax Credits for Personal Assistance Services (PAS) Costs

The proposal would provide a nonrefundable tax credit to people with disabilities for up to 50 percent of their personal assistance services (PAS) expenses up to the lesser of $15,000 or the individual's earned income. The tax credit rate would be phased down for taxpayers with modified aggregate gross income (AGI) over $50,000.

The 1990 SIPP data were used to estimate the number of persons with disabilities qualified for the PAS tax credit under the proposal. The SIPP data contain disability-related information on individuals who require assistance in activities of daily living (ADLs), such as the type of ADLs, their care arrangements, and out-of-pocket PAS expenses. Demographic information and employment and earning status of these individuals are also available from the SIPP database.

The revenue estimates include the static revenue loss from those qualified individuals who are currently employed, as well as the effect of two behavioral changes. First, the proposal would increase employment of qualified individuals with disabilities, which would increase the revenue loss because of the increased use of the credit. Second, the proposal would encourage certain persons with disabilities and employed individuals, who are currently assisted by relatives and friends, to switch to paid help. Because the SIPP data only provide information on out-of-pocket PAS costs and not total PAS costs, data from the 1987 NMES file were used to project total costs for those

individuals switching to paid help. Finally, the Treasury Individual Tax Model was used to estimate the effective tax rate and the credit usage rate for those individuals who may qualify for the tax credit.