CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

March 24, 2016

H.R. 4725
Common Sense Savings Act of 2016

As ordered reported by the House Committee on Energy and Commerce on March 15, 2016

SUMMARY

H.R. 4725 would make changes to Medicaid and the Children's Health Insurance Program (CHIP) that would reduce the federal medical assistance percentages (FMAPs) for certain enrolled individuals. The bill would also limit states' ability to tax health care providers and require states to include lottery winnings or lump sum income in determining eligibility for Medicaid. Lastly, the bill would repeal the Prevention and Public Health Fund (PPHF), which provides grants to carry out prevention, wellness, and public health activities.

CBO estimates that enacting the legislation would reduce federal deficits by $29.6 billion over the 2016-2026 period. That total consists of $29.4 billion in on-budget savings and $0.2 billion in off-budget savings. Pay-as-you-go procedures apply because enacting the legislation would affect direct spending and revenues.

CBO estimates that enacting the legislation would not increase net direct spending or on-budget deficits by more than $5 billion in any of the four consecutive 10-year periods beginning in 2027.

H.R. 4725 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA).

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary effects of H.R. 4725 are shown in the following table. The costs of this legislation fall within budget function 550 (health).

	By Fiscal Year, in Millions of Dollars												
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2016-2021	2016-2026
CHANGES IN DIRECT SPENDING													
Treatment of Lottery Winnings and Other Lump-Sum Income													
Estimated Budget Authority	0	0	-30	-45	-45	-50	-55	-55	-60	-65	-70	-170	-475
Estimated Outlays	0	0	-30	-45	-45	-50	-55	-55	-60	-65	-70	-170	-475
Eliminating Enhanced FMAP for Prisoners													
Estimated Budget Authority	0	-85	-150	-190	-195	-210	-220	-230	-240	-250	-255	-830	-2,025
Estimated Outlays	0	-85	-150	-190	-195	-210	-220	-230	-240	-250	-255	-830	-2,025
Extending the Threshold for Determining Acceptable Provider Taxes													
Estimated Budget Authority	0	0	-400	-450	-450	-500	-500	-550	-550	-600	-600	-1,800	-4,600
Estimated Outlays	0	0	-400	-450	-450	-500	-500	-550	-550	-600	-600	-1,800	-4,600
Sunsetting the CHIP Enhanced FMAP Increase													
Estimated Budget Authority	-1,500	-3,135	-2,485	-300	0	0	0	0	0	0	0	-7,420	-7,420
Estimated Outlays	-1,500	-3,135	-2,485	-300	0	0	0	0	0	0	0	-7,420	-7,420
Repeal of the Prevention and Public Health Fund													
Estimated Budget Authority	-632	-1,000	-1,250	-1,250	-1,500	-1,500	-2,000	-2,000	-2,000	-2,000	-2,000	-7,132	-17,132
Estimated Outlays	-170	-429	-831	-1,091	-1,280	-1,380	-1,589	-1,759	-1,941	2,000	-2,000	-5,181	-14,470
Total Changes													
Estimated Budget Authority	-2,132	-4,220	-4,315	-2,235	-2,190	-2,260	-2,775	-2,835	-2,850	-2,915	-2,925	-17,352	-31,652
Estimated Outlays	-1,670	-3,649	-3,896	-2,076	-1,970	-2,140	-2,364	-2,594	-2,791	-2,915	-2,925	-15,401	-28,990
CHANGES IN REVENUES													
Estimated Revenues	0	0	120	505	-1	0	0	0	0	0	0	624	624
On Budget	0	0	80	335	-1	0	0	0	0	0	0	414	414
Off-Budget [a]	0	0	40	170	0	0	0	0	0	0	0	210	210
NET DECREASE (-) IN THE DEFICIT													
Impact on Deficit	-1,670	-3,649	-4,016	-2,581	-1,969	-2,140	-2,364	-2,594	-2,791	-2,915	-2,925	-16,025	-29,614
On Budget	-1,670	-3,649	-3,976	-2,411	-1,969	-2,140	-2,364	-2,594	-2,791	-2,915	-2,925	-15,815	-29,404
Off-Budget	0	0	-40	-170	0	0	0	0	0	0	0	-210	-210

Notes: Components may not add to totals because of rounding; CHIP = Children's Health Insurance Program; FMAP = Federal Medical Assistance Percentage.

a. All off-budget effects would come from changes in Social Security revenues.

BASIS OF ESTIMATE

For this estimate, CBO assumes that the legislation will be enacted by the end of June 2016. Enactment at a later date would reduce the amount of estimated savings.

Changes in Direct Spending

CBO estimates that enacting H.R. 4725 would reduce net direct spending by about $29 billion over the 2016-2026 period.

Treatment of Lottery Winnings and Other Lump-Sum Income. Section 2 of the bill would require states to treat monetary winnings from lotteries and lump sum forms of income from gambling, legal judgements, and inheritances as income for purposes of determining Medicaid eligibility. The length of time over which the amounts would be counted as income would depend on their size, with larger amounts counting as income over a longer period of time.

Under current law, most non-disabled adults who apply for Medicaid, and have substantial funds in a bank account gained previously from the sources mentioned, can still qualify for Medicaid because the eligibility rules do not permit assets such as funds in a bank account to be considered when determining eligibility. Similarly, although most enrollees who gain substantial lump-sum income must report that income to state Medicaid agencies, which would cause them to lose their coverage, those individuals can reapply again at a later date when the income will be treated as an asset that will no longer affect their eligibility.

Section 2 would treat lottery winnings and other lump sum income as income for an extended period of time based on the amount of income, which would prevent some individuals from receiving Medicaid for the duration of the applicable time period. Based on data supplied by the state of Michigan on lottery winners in that state and additional information collected from the lottery industry, and because the probability of receiving large sums from lotteries or other sources (among low-income individuals) is relatively low, CBO estimates that the number of people who would lose Medicaid would be modest, ranging from 9,000 to 10,000 in any given month in most years of the budget window. Using the typical per capita cost for Medicaid adults, CBO estimates that this provision would reduce direct spending by $475 million over the 2016-2026 period.

Eliminating Enhanced Medicaid FMAP for Prisoners. Section 3 would eliminate, beginning on January 1, 2017, the enhanced matching rate made available by the Affordable Care Act (ACA) for prisoners in correctional facilities. Under current law, states cannot receive federal Medicaid matching funds for medical care provided to inmates who are otherwise eligible for Medicaid except when they are hospitalized for at least 24 hours. In the event of such a hospitalization, Medicaid covers the federal share of the costs associated with the hospitalization. Because a large percentage of inmates are

low-income adults without dependent children, they would qualify for Medicaid through the eligibility category established by the ACA (31 states and the District of Columbia have adopted the optional eligibility category). As a result, the costs associated with 24-hour hospitalizations for these inmates would be matched by the federal government at the enhanced rates established for this eligibility category (95 percent in 2017 phasing down to 90 percent in 2020 and thereafter), rather than the standard matching rates that apply to all other Medicaid enrollees (57 percent, on average).

Section 3 would reduce Medicaid outlays by paying the lower standard matching rates for inmate hospitalizations. According to data on the number of prisoners published by the Bureau of Justice Statistics, CBO estimates that about 400,000 state prisoners would be eligible for Medicaid in 2017 rising to about 900,000 by 2026 (the number grows substantially because, over time, CBO expects that more states will adopt the ACA expansion and more states will take the necessary steps to enroll their prison populations). Based on information provided by prison healthcare experts, CBO estimates that hospitalizations requiring a stay of at least 24 hours are rare, occurring for about 5 percent of the eligible population per year on average. Therefore, spending for between 20,000 and 45,000 state prisoners would be affected depending on the year. The cost for prisoners who meet the hospitalization criteria is estimated to range between $14,000 in 2017 to $18,000 in 2026 and the federal government would save about one-third of those amounts based on the difference between the higher enhanced matching rates and the lower standard matching rates. In total, CBO estimates that this provision would reduce direct spending by $2.0 billion over the 2016-2026 period.

Extending the Threshold for Determining Acceptable Provider Taxes. Under current law, the federal government reduces Medicaid reimbursement to states in an amount equal to any impermissible state tax revenues collected from health care providers. While there are several ways in which state taxes on health care providers can be impermissible, in one instance, state taxes on health care providers are generally impermissible if a state enters into an agreement to hold providers harmless for the taxes collected through higher payment rates. Federal law currently grants an exception to this prohibition on hold harmless arrangements, known as a "safe harbor," that deems taxes as permissible as long as the collections total no more than 6 percent of provider revenues. Section 4 of the bill would reduce the safe harbor threshold from 6 percent to 5.5 percent, starting on January 1, 2018.

Lowering the safe harbor threshold would lower the amount of revenues that states could collect from providers. Based on analysis of data from the Centers for Medicare and Medicaid Services (CMS) regarding state tax rates on different types of providers, CBO estimates that just less than half of states collect provider tax revenues above the threshold established by the bill.

By restricting the revenue that states may collect from providers to finance the state share of Medicaid spending, some states would be faced with a choice under H.R. 4725. They could decide to continue to spend the same amount on Medicaid as before, replacing all of the lost provider revenue with a different source of revenue (or by reducing non-Medicaid programs). In that instance, federal Medicaid spending would be unchanged (the federal government would match the same amount of state spending). Alternatively, states could decide not to replace the lost revenue from providers and instead cut their state spending on Medicaid by the amount of the lost revenues. That choice would reduce federal Medicaid spending (the federal government would match a lower level of state spending). CBO expects that different states would respond to the change in the safe harbor threshold in different ways along this continuum and that, on average, states would replace about half of the lost provider revenues.

Based on the amount of revenue above the 5.5 percent threshold that would be collected by states under current law and the expectation that states would replace half of the lost revenue, CBO estimates that this provision would reduce direct spending by $4.6 billion over the 2016-2026 period.

Sunsetting the Enhanced FMAP Increase. Section 5 of H.R. 4725 would eliminate the temporary 23 percentage point increase in the share of CHIP expenditures that the federal government will pay through 2019 under current law. CBO estimates the provision would reduce spending by $7.4 billion over the 2016-2026 period. This amount includes changes in spending for CHIP, Medicaid, and subsidies for insurance purchased through health insurance marketplaces.

Children's Health Insurance Program. Starting in fiscal year 2016, the federal share of most CHIP expenditures increased by 23 percentage points (with the state share decreasing by an equivalent amount). The bill would terminate that increase effective March 30, 2016, reducing the federal share from an average of 92 percent to 70 percent (some states did not receive the full 23 percentage point increase because the federal share would have exceeded 100 percent).

CBO estimates that under the bill the average annual cost to the federal government for each CHIP enrollee would decrease by about $250 in 2016 and by between $500 and $650 in 2017 through 2019. While this difference in federal cost would increase costs for states, CBO does not project that the bill would prompt any change in state rules for benefits or eligibility because current law prohibits states from implementing restrictions on their programs prior to 2020. Based on projected enrollment of about 5.7 million people in 2016 and 2017, we estimate that this provision would reduce direct spending in CHIP by $1.5 billion and $3.1 billion in those years, respectively.

CBO estimates that section 5 would save the program less in 2018 and 2019 because funding for CHIP under current law is projected to decrease significantly after 2017.[1] With lower overall spending, a reduction in the federal share of costs would yield smaller savings. In addition, because CBO expects that states will enroll as many children as possible with the lower level of funding in those years, some of the savings generated by the bill would be used to provide coverage for children not otherwise able to enroll in CHIP because of budgetary constraints. On net, CBO estimates that the provision would decrease direct spending by $1.7 billion in 2018 and increase direct spending by $3.1 billion 2019 (these amounts would be offset by savings from other programs, discussed below). Enrollment in CHIP would increase by 660,000 in 2018 and 2.6 million in 2019, CBO estimates.

Medicaid and Subsidies for Insurance Purchased through Marketplaces. CBO expects that many children who would enroll in CHIP as a result of this bill would have otherwise received coverage from other sources. Some would have been eligible for and received Medicaid benefits (at the regular Medicaid match rate). Others would have received subsidies for coverage obtained through health insurance marketplaces. CBO estimates the savings to those programs would total $4.2 billion over the 2016-2026 period.[2]

Repeal of the Prevention and Public Health Fund. The Prevention and Public Health Fund provides funds to federal agencies to award grants to public and private entities to carry out prevention, wellness, and public health activities. Under current law, between $1 billion and $2.0 billion is made available to the fund each year. Section 6 of H.R. 4725 would prevent the Department of Health and Human Services from obligating any additional amounts through the fund. CBO expects that the bill would prevent approximately $700 million from being obligated in 2016 as well as the full amounts scheduled to be provided in each subsequent fiscal year. As a result, CBO estimates that enacting the bill would reduce direct spending by $14.5 billion over the 2016-2026 period.

Changes in Revenues

CBO expects that some children who would enroll in CHIP as a result of section 5 of the bill would have otherwise received insurance coverage from a parent's employer. Those shifts would generally result in higher taxable income for affected workers, because they

1. The Congress has not provided funding for CHIP beyond 2017; however, pursuant to the rules that govern CBO's baseline, certain expiring programs, such as CHIP, are assumed to continue in the baseline. In accordance with those rules, CBO's most recent baseline projections reflect the assumption that funding in each year over the 2018–2026 period will be equal to a portion of the funding provided for CHIP in 2017—$5.7 billion.

2. Subsidies are provided in the form of tax credits for premium assistance and reductions in out-of-pocket spending. The subsidies for health insurance premiums are structured as refundable tax credits. Following the standard budgetary treatment for such credits, the portions that exceed taxpayers' income tax liabilities are classified as outlays in baseline projections and the portions that reduce tax payments are classified as reductions in revenues. All subsidies for out-of-pocket spending are classified as outlays.

would receive less of their income in nontaxable health benefits and more in taxable wages. CBO estimates that the decrease in employment-based coverage from enacting H.R. 4725 would increase revenues by about $550 million over the 2016-2026 period. That total consists of about $340 million in on-budget revenues and about $210 million in off-budget revenues because some of the increase in revenues would come from Social Security payroll taxes.

In addition, some children who would enroll in CHIP under the bill would have otherwise received subsidies for the purchase of insurance through health insurance marketplaces in the form of a tax credit, reducing revenues to the federal government. CBO estimates that reducing the number of people receiving subsidies for insurance purchased through the marketplaces would increase revenues by about $70 million over the 2016-2026 period.

PAY-AS-YOU-GO CONSIDERATIONS

The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues. The net changes in outlays and revenues that are subject to those pay-as-you-go procedures are shown in the following table. Only on-budget changes to outlays or revenues are subject to pay-as-you-go procedures.

CBO Estimate of Pay-As-You-Go Effects for H.R. 4725, as ordered reported by the House Committee on Energy and Commerce on March 14, 2016

	By Fiscal Year, in Millions of Dollars												
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2016-2021	2016-2026
NET INCREASE OR DECREASE (-) IN THE ON-BUDGET DEFICIT													
Statutory Pay-As-You-Go Impact	-1,670	-3,649	-3,976	-2,411	-1,969	-2,140	-2,364	-2,594	-2,791	-2,915	-2,925	-15,815	-29,404
Memorandum:													
Changes in On-Budget Outlays	-1,670	-3,649	-3,896	-2,076	-1,970	-2,140	-2,364	-2,594	-2,791	2,915	-2,925	-15,401	-28,990
Changes in On-Budget[a] Revenues	0	0	80	335	-1	0	0	0	0	0	0	414	414

a. For revenues, a positive number indicates an increase (reducing the deficit) and a negative number indicates a decrease (adding to the deficit).

INCREASE IN LONG-TERM DIRECT SPENDING AND DEFICITS

CBO estimates that enacting H.R. 4725 would not increase net direct spending or on-budget deficits by more than $5 billion in any of the four consecutive 10-year periods beginning in 2027.

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

H.R. 4725 contains no intergovernmental or private-sector mandates as defined in UMRA. By modifying calculations for income eligibility in Medicaid, prohibiting enhanced FMAP Medicaid payments to some incarcerated individuals, lowering the safe harbor threshold for state provider tax collections, and eliminating the temporary increase in enhanced FMAP payments under CHIP, CBO estimates that the bill would reduce federal spending in the Medicaid and CHIP programs. Those reductions in federal spending would total about $15 billion over the 2016-2026 period. To continue providing services that otherwise would be supported by those funds, states would need to use their own resources.

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