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# ASSESSING THE EFFECTS OF THE BUDGET CONFERENCE AGREEMENT ON LOW-INCOME FAMILIES AND INDIVIDUALS

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Some Congressional leaders are claiming that the low-income provisions in the conference agreement on the budget reconciliation bill are modest and will not harm vulnerable families. Many of the legislation's key provisions were altered behind closed doors in weekend negotiations, and the legislation was not released until after 1:00 the morning of December 19, just hours before House members had to vote on the legislation. Not surprisingly, there was considerable confusion over what the legislation actually does when the House passed it.

Because the Senate subsequently deleted several minor provisions from the conference agreement before it passed it, the legislation has to go back to the House for another vote. When the House acts this time, perhaps as early as February 1, there should be no confusion about what the legislation would do.

**KEY FINDINGS**

- **The budget agreement would cause considerable hardship among low-income families and individuals and is closer in key respects to the original House-passed bill than the Senate bill.**
- **Cuts in the final bill include: $16 billion over 10 years in increased Medicaid co-payments and premiums and benefit reductions; new federal mandates in the welfare area that would lead to a loss of an estimated 255,000 child care slots for low-income working families not receiving cash welfare assistance; and nearly $8 billion in lost child support collections over the next 10 years.**
- **Such cuts could have been largely or fully averted had the conferees not dropped several Senate provisions that would have achieved substantial savings in reining in excessive Medicare payments to managed care companies and securing better prices from pharmaceutical companies for drugs dispensed though Medicaid.**
- **The savings that the budget agreement produces are expected to be used *not* to reduce the deficit, but to help finance several tax cuts slated to be enacted early next year that will primarily benefit high-income individuals.**

Careful examination of the legislation shows that the conference agreement would, in fact, cause considerable hardship among low-income families and individuals. The legislation contains cuts in various low-income areas, including Medicaid, that would directly affect low-income families and individuals and are closer to provisions in the original House-passed reconciliation bill than to the provisions of the Senate bill. This is due in no small part to action by the conferees to shield certain powerful special interests — principally pharmaceutical companies and the managed care industry — and instead to extract sizable savings from low-income families.

The cuts in the conference agreement include:

- **Increases in Medicaid co-payments and premiums, and reductions in Medicaid benefits, that total $16 billion over the next ten years, according to the Congressional Budget Office.** None of these provisions were included in the Senate bill. The increases in co-payments for health care services would be especially large for people just above the poverty line, who could find themselves charged $20 to $100 or more for some health care services for which they now are charged no more than $3.

- **The most substantial — and controversial — changes in welfare policy since 1996, none of which were included in the Senate bill.** The changes include: expensive and unfunded new requirements that would be imposed on states (according to CBO, these new requirements are more expensive than the controversial requirements included in the House bill); the elimination of state flexibility in designing work requirements for low-income families served entirely with the state's own funds; and provisions that would encourage states to *exclude* poor two-parent families from assistance. In addition, child care would be heavily under-funded: by 2010, an estimated 255,000 fewer children in low-income working families not receiving cash welfare assistance would receive child care aid than received it in 2004.

- **Significant cuts in a variety of other low-income areas.** The conference agreement does not include any of the food stamp cuts included in the House bill but includes significant cuts in a number of other low-income programs. The conference agreement's reductions in child support enforcement funding would, according to CBO, mean that $2.9 billion in child support that otherwise would be collected over the next five years — and $8.4 billion that otherwise would be collected over the next ten years — would go *uncollected* instead. The conference agreement also includes provisions that would delay certain SSI payments for up to a year for many poor individuals with disabilities who are found eligible for SSI. In addition, the bill cuts federal foster care aid in a way that will make it much more difficult for states to provide federally funded foster care benefits to certain relatives who are raising children because the children's parents are unable or unfit to do so. None of these programs were cut in the Senate bill.

These cuts to low-income programs could have been averted in large part or entirely — and the same amount of savings still achieved — if the conferees had done more to tackle certain special interests. The conference agreement caters to a large degree to the powerful pharmaceutical and managed care industries by dropping several key provisions of the Senate bill that would have secured substantial savings by reining in excessive costs related to those industries in the Medicare and Medicaid programs.

- The conference agreement drops Senate-passed provisions that would increase the minimum rebates that drug manufacturers are required to pay to Medicaid and extend the rebates to drugs that are dispensed through Medicaid managed care plans. (The agreement only includes two minor rebate provisions instead).

- The agreement also drops a Senate provision that would have eliminated a $10 billion fund to encourage participation in *Medicare* by regional Preferred Provider Organizations. Congress' own official expert advisory panel has found this fund to be unnecessary and unwarranted.

Before describing various low-income provisions of the conference agreement in more detail, two final points bear noting. First, much of the confusion and misinformation surrounding the conference

agreement reflects the unusual process in which it was unveiled. The conference agreement, which runs 774 pages, was written behind closed doors and was not made available to Members of the House or the public until 1:12 AM Monday morning. The House then began voting on the legislation at 5:43 AM Monday morning, with little opportunity for Members to learn what the legislation actually did in a number of key policy areas.

The normal rules of the House call for at least one day between the filing of major legislation and votes on it. Those rules were waived at about midnight last night, however, as a result of the House Leadership's invoking a procedure known as "martial law."[1]

Second, these cuts would *not* be used to reduce the deficit or to offset the costs of hurricane relief and reconstruction for the Gulf Coast region. The savings from these budget cuts would effectively be used instead to offset part of the cost of pending tax-cut bills that are expected to be enacted in early 2006. Those tax-cut bills would cost *more* than the budget-cut legislation would save, so there would be a net increase in the deficit. The tax cuts also would disproportionately benefit affluent individuals.

## MEDICAID

***The reconciliation conference agreement includes substantial Medicaid cuts aimed at the program's low-income beneficiaries.***

The reconciliation conference report includes *gross* expenditure reductions of $11 billion in Medicaid over five years and $42 billion over ten years. Some press reports have focused on the *net* cuts to Medicaid of $5 billion over five years (and $27 billion over ten years); the net savings are smaller because they reflect the cost of provisions included in the legislation to defray costs that various states are incurring in providing Medicaid coverage to low-income survivors of Hurricane Katrina, as well as the cost of continuing a longstanding component of Medicaid that maintains Medicaid coverage for up to a year for families that work their way off welfare and the cost of a few other provisions, such as a new option for disabled children with incomes above the Medicaid income limits to "buy into" Medicaid. The "gross" cut figure more accurately represents the cuts in health care services current Medicaid beneficiaries will bear in the coming years.

A large share of the conference agreement's Medicaid savings is achieved by provisions similar to those in the House-passed reconciliation bill that would require low-income Medicaid beneficiaries to pay more out-of-pocket for health care or reduce the health care services for which many beneficiaries are covered. The conference report largely forgoes the Senate reconciliation bill's more balanced approach; the Senate bill avoided changes that would harm low-income beneficiaries by achieving greater savings in the area of Medicaid prescription drug pricing and by doing more to reduce excessive payments made to Medicare managed care plans.

[1] Robert Greenstein, "House Leadership Seeks to Invoke 'Martial Law,' Forcing Members to Vote on Key Budget Bills Without Full Knowledge of What They Are Voting On," Center on Budget and Policy Priorities, December 18, 2005.

Key aspects of the Medicaid part of the conference report include the following.

**Substantial increases in co-payments and premiums for many beneficiaries, including near-poor children**. The conference agreement permits large increases in the cost-sharing charges imposed on low-income Medicaid beneficiaries through provisions broadly similar to those included in the House bill. CBO's cost estimates confirm the similarity between the conference agreement and the House bill in this area, showing that the reductions in Medicaid expenditures due to increases in co-payments and premiums are *80 percent* as large over five years as the comparable reductions in the House bill, and *90 percent* as large over ten years. A substantial body of research has shown — and CBO also has concluded — that such increases in co-payments and premiums are likely to lead many low-income Medicaid patients to forgo needed health care services and medications and to induce some (as a result of the imposition of premiums) to fail to enroll in Medicaid at all.

Under current law, states may not charge premiums to Medicaid beneficiaries, and generally may charge co-payments of no more than $3 for each service or medication, with some populations — including children — fully exempt from co-payments and premiums. The conference agreement would significantly alter these rules, permitting cost-sharing increases for six million children on Medicaid and many other low-income beneficiaries. The cost-sharing provisions in the conference agreement include the following.

- For many near-poor Medicaid beneficiaries with incomes between 100 percent and 150 percent of the poverty line (between about $16,000 and $24,000 for a family of three), states could charge co-payments of up to *10 percent* of the cost of the needed medical service. For example, in one state, a typical inpatient hospital day may cost between $1,000 and $1,600. A 10 percent co-payment would equal $100 to $160. Similarly, a procedure such as an endoscopy, a cataract removal, or removal of a growth that could develop into melanoma can cost $200 to $800 so the copayment could be as high as $80. The co-payment charge today for these services is set at a maximum of $3, a protection designed to help ensure that beneficiaries can obtain care they need.

- For many low-income beneficiaries with incomes above 150 percent of the poverty line, states could charge substantial premiums to participate in Medicaid and could also charge co-payments of up to *20 percent* of the cost of the needed medical service.

- For many beneficiaries with incomes *below* the poverty line, the legislation intends that states could increase the existing nominal co-payment charge of $3 per health care service or medication each year by the percentage increase in the medical care component of the Consumer Price Index. The medical care component of the CPI has been rising *twice as fast* as the general inflation rate, however, and thus at least twice as fast as poor beneficiaries' incomes. (Due to a serious legislative drafting error, poor beneficiaries actually could end up being charged unlimited co-payments and unlimited premiums, although that evidently was not what the conferees intended. Such errors are more common when legislation is drafted in secret and only a few staff are permitted to review the language before it is filed and rushed to a vote.)

- The only limit on the cost-sharing increases under the legislation is that total cost-sharing may not exceed five percent of a family's income over a three month period. (This means that if a family suddenly experienced a major health problem, the family might face co-payment charges that substantially exceeded 5 percent of its income in a single month before it reached the limit of five percent of its quarterly income.) A significant body of research has found that cost-sharing

charges of significantly *less* than five percent of income induce substantial numbers of low-income people to forgo health care services or medications, and that some such individuals become sicker as a result.

**Benefit reductions that could affect working-poor parents and nearly all of the 28 million children who receive Medicaid coverage.** The conference report retains about one-third of the House-passed cuts that would, for many Medicaid beneficiaries, eliminate the federal standards which assure that Medicaid beneficiaries receive comprehensive health care coverage. Under the conference agreement, states would be allowed to substitute substantially scaled-back coverage for various groups of beneficiaries, including working-poor parents. The savings are smaller in this area than under the House bill primarily because the conference agreement exempts more beneficiaries from this provision, including people with disabilities.

This aspect of the conference agreement could affect children — including children below the poverty line — in a particularly problematic way. Under the House bill, poor children would have been exempt from this provision and would have retained the benefit protections provided under current law. Under the conference report, by contrast, the vast majority of children enrolled in Medicaid, including those below the poverty line, could effectively lose access to the comprehensive health care coverage they now are guaranteed through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) component of Medicaid. The conference agreement allows states to provide scaled-back benefit packages to children, as long as the states that do so "wrap around" those scaled-back benefit packages so that overall coverage remains available for the same health care services that currently must be made available under EPSDT. This approach is unlikely to work well in practice, however: examination of how "wrap-around" coverage currently works for children in Medicaid managed care plans shows that such coverage can be ineffective and that children in managed care often go without some needed care as a result.

**Citizenship documentation that would likely decrease Medicaid coverage among eligible U.S. born citizens, especially elderly African-Americans.** The conference agreement also imposes a new Medicaid mandate on states, essentially requiring that native-born citizens applying for Medicaid must provide a birth certificate or passport to demonstrate their citizenship.[2] This provision is said to be intended to deter illegal immigrants from falsely claiming citizenship to obtain Medicaid. An extensive study issued last summer by the HHS Office of the Inspector General, however, found *no* substantial evidence that such false applications are actually occurring, and OIG accordingly did *not* recommend making the change that is included in the conference agreement.

This provision is virtually certain to create serious barriers for native-born citizens who apply for Medicaid but lack ready access to a birth certificate or passport. Many individuals who require Medicaid coverage — such as people affected by emergencies like Hurricane Katrina, homeless people, or those with mental illness — may be unable to get Medicaid promptly when they need it because they do not have such documents in their possession.

[2] Naturalized citizens may present their naturalization papers. The legislation would permit drivers' licenses (or other forms of identification) as documentation of citizenship, but only if the state issued drivers' licenses (or such other forms of identification) *solely* to citizens *and* obtained proof of citizenship before issuing those forms of ID. Since all states issue drivers' licenses to both citizens and legal non-citizen immigrants, no state could meet that requirement.

There also are significant civil rights implications. A large number of elderly African-Americans lack birth certificates because they were born in an era when African-Americans (especially in the South) had less access to hospitals due to racial discrimination and thus never received birth certificates. One study estimated that as many as one in every five African-Americans born around 1940 lacks a birth certificate.[3] Such people may now be disqualified from Medicaid as a consequence. (The Leadership Conference on Civil Rights sent a strong letter to the Congressional Leadership last week beseeching it not to include this provision in the conference agreement. The Leadership evidently ignored the request.)

**Overly restrictive asset transfer rules for people who need nursing home care.** The conference report adopts most of the provisions in the House-passed bill to restrict eligibility for Medicaid long-term care services, and many of the Senate provisions in this area as well. Under the conference agreement, the savings in this area would be 11 percent *larger* than under the House bill, and seven times larger than under the Senate bill.

Preventing more-affluent individuals from sheltering assets that could be used to pay for their long-term care is a very laudable goal. The provisions in the conference agreement, however, go well beyond it. The largest share of the savings in this area in the conference report come from a provision that would penalize many non-affluent individuals who make modest gifts to relatives or contributions to charity and then experience an unexpected decline in their health *several years later* that causes them to need long-term care.

## Catering to Special Interests

The conference report's health care provisions move toward the House bill in another respect, as well: they cater to the pharmaceutical and managed care industries at the expense of low-income beneficiaries.

- **No increase in drug manufacturer rebates.** The Senate bill avoided harmful co-payment and premium increases and benefit reductions in part because it achieved much of its Medicaid savings by restraining the amounts that Medicaid pays for prescription drugs. To ensure that Medicaid gets the best prescription drug prices, the Senate bill increased the minimum rebates that drug manufacturers are required to pay the Medicaid program for drugs dispensed to Medicaid beneficiaries. The Senate bill also applied the rebates to drugs provided to Medicaid beneficiaries through managed care plans. The Senate drug rebate provisions produced Medicaid savings of $3.9 billion over five years and $10.5 billion over ten years, which helped the Senate reach its savings target without harming low-income beneficiaries.

  In a victory for the powerful pharmaceutical industry, the conference agreement fails to include the Senate's significant rebate provisions. The conference agreement includes only two minor provisions related to drug rebates already included in both the House-passed and Senate-passed bills; these provisions generate savings of only $220 million over five years and $720 million over ten years, or 2 percent of the gross Medicaid savings in the conference agreement.

[3] S. Shapiro, "Development of Birth Registration and Birth Certificates in the United States," *Population Studies*, 4:86-111, 1950. Cited by I. Rosenwaike and M. Hill, "The Accuracy of Age Reporting Among Elderly African-Americans: Evidence of a Birth Registration Effect," Population Aging Research Center, Univ. of Pennsylvania, Working Paper, July 1995.

- **No elimination of the Medicare stabilization fund.** The conference report also protects Medicare managed care plans. It drops a Senate provision that would have eliminated a wasteful $10 billion fund to encourage participation in Medicare by regional Preferred Provider Organizations (PPOs). The Medicare Payment Advisory Commission (MedPAC) — the official, independent advisory body to Congress on Medicare payment policy — recommended last summer in a nearly unanimous vote that this fund be eliminated because it is unnecessary and unwarranted and provides an unfair competitive advantage to PPOs over traditional Medicare fee-for-service and other managed care plans, such as Medicare HMOs. Nevertheless, the conference agreement leaves this fund fully intact, forgoing $5.4 billion in savings over five years (and twice that over ten years) contained in the Senate bill. The removal of this Senate provision likely was done at the behest of the managed care industry and the Administration, which threatened to veto the budget bill if the Senate provision was included in the final conference agreement.

- **Partially gutting another provision to curb overpayments to managed care plans**. There is near-universal agreement among analysts that the current Medicare payment structure provides excessive payments to managed care plans, and the Administration announced earlier this year that it would act administratively to eliminate a feature of the payment formula that is responsible for a significant volume of excessive payments.[4] MedPAC endorsed the Administration's action, and the Senate reconciliation bill wrote the Administration's planned administrative action into law, for savings of $6.5 billion over five years and $26 billion over ten years, according to CBO. Under the conference agreement, however, the ten-year savings have shrunk from $26 billion to $4.1 billion, according to the CBO estimates. The conference agreement rewrote the provision so that after five years, managed care plans could again receive the overpayments this provision is supposed to curb, with future administrations being precluded from taking steps through administrative action that would effectively curtail the overpayments.[5]

In short, in place of the Senate's reasonable savings from eliminating the wasteful Medicare stabilization fund and lowering the prices that Medicaid pays pharmaceutical companies for prescription drugs, the conference agreement includes a hefty share of the House Medicaid provisions on cost-sharing and benefits, even though medical research indicates that these changes are likely to reduce the affordability and accessibility of health care for substantial numbers of low-income patients.

## LOW-INCOME PROGRAMS OUTSIDE THE HEALTH AREA

[4] Through a process known as "risk adjustment," payments to Medicare managed care plans are adjusted to ensure that Medicare does not overpay private plans if the beneficiaries enrolled in such plans are healthier, and thus less costly to treat, than the beneficiaries enrolled in traditional Medicare fee-for-service. These adjustments, however, are currently being offset by "hold harmless" payments that artificially inflate Medicare reimbursement rates to these plans. The Administration has proposed to phase out the "hold harmless" payments over three years.

[5] Specifically, after five years, the conference agreement prohibits the Secretary of Health and Human Services from modifying the risk adjustment formula to compensate for differences in coding patterns (which reflect how patient diagnoses and procedures are classified for purposes of reimbursement) between Medicare managed care plans and traditional fee-for-service. Without this authority, managed care plans can offset the loss of the "hold harmless" payments by upcoding patient diagnoses and procedures to reduce the size of risk adjustments. The Congressional Budget Office has reportedly assumed that without the authority to prevent such upcoding, most of the savings from reducing these overpayments to managed care plans will disappear.

The Senate reconciliation bill did not include cuts in any low-income program other than Medicaid and did not seek to rewrite the welfare reform rules in a reconciliation bill. The conference agreement, by contrast, includes sizeable cuts in child support enforcement, SSI, and foster care, as well as highly controversial TANF provisions that would impose expensive, unfunded work requirements on states and result in the loss of child care for many low-income working families not receiving TANF cash assistance.

**1. Child Support Enforcement:** The CBO estimates show that the conference report includes a $1.5 billion cut in federal funding for child support enforcement efforts over the next five years and a $4.9 billion cut over the next ten years. This is funding that states use to track down absent parents, establish legally enforceable child support orders, and collect and distribute child support owed to families. *CBO has estimated that this loss in federal child support funding will result in $2.9 billion in child support going uncollected over the next five years and $8.4 billion going uncollected over the next ten years.* These cuts are smaller than those in the House bill but will nevertheless take billions of dollars out of the pockets of mothers and children who are owed child support. (The conference agreement also contains some modest improvements in the child support program. The cuts in federal support for the program and the associated loss of child support collections, however, far outweigh the modest benefits that some families would see as a result of a few improvements in other child support provisions.)

**2. TANF:** The TANF provisions in the conference report represent the largest change in welfare policy since 1996. CBO analyses show that the conference agreement would impose very expensive new work requirements on states. The bill also provides the U.S. Department of Health and Human Services with vast new regulatory authority to micromanage how states operate their welfare-to-work programs, down to new, unfunded paperwork requirements for tracking participation in work activities. In addition, in a major change in policy that goes well beyond anything in any prior TANF bill, including the TANF provisions in the House-passed budget reconciliation bill, the conference agreement would remove from states the flexibility they now have to apply different types of work-related requirements to people receiving assistance that is funded *entirely with state* "maintenance of effort" funds. (These are state funds that a state must expend to draw down federal TANF funds.) Finally, the bill includes provisions that will virtually guarantee that any state that provides income assistance to poor two-parent families will face fiscal penalties for failing to meet the work participation requirements that would be specifically applied to those families, which independent researchers and state officials uniformly agree are unattainable even in the most effectively run program. As a result, many states may sharply curtail assistance to such families.

CBO estimates that if states attempt to meet the work requirements in the conference agreement by placing more parents in welfare-to-work programs (rather than by reducing the number of poor families receiving assistance at all), the cost to states would exceed $8.4 billion over the next five years, which is *higher* than the cost would have been under the House reconciliation bill. (The $8.4 billion figure excludes the cost to states of meeting the very high work participation rates for two-parent families, discussed below.) States would have to meet the new work requirements beginning in fiscal year 2007, which starts just ten months from now. CBO projects that some states would fail to meet the new mandates and would face fiscal penalties as a consequence. CBO also expects states to try to cope with the federal mandates by increasing the number of families who are sanctioned off the program and by imposing new barriers to poor families seeking assistance. This is likely to lead to more children living in deep poverty.

It is widely known that there was a concerted effort in the conference to redesign the bill's work requirements so that the Congressional Budget Office would conclude that some states would not be able to meet the requirements and thus would be subject to fiscal penalties. This was purposefully done to attempt to get around the "Byrd rule," which is a Senate rule that generally prohibits policy changes that do not have a budgetary impact from being included in a reconciliation bill. The goal here appears to have been less to craft good policy than to secure an estimate from CBO that the changes in the work requirements would, in fact, save money for the federal Treasury — and to do so by making the new requirements sufficiently unrealistic that some states would not be able to meet them and would face fiscal penalties. (It is not yet known whether the TANF work provisions in the conference agreement will succeed in meeting the Byrd rule test when the bill goes to the Senate floor.)

The conference report imposes particularly unrealistic work requirements on two-parent families. Under the conference agreement, 90 percent of all two-parent families receiving assistance would have to participate in work activities each month for at least 35 hours each week. This requirement would apply to two-parent families in federally-funded TANF programs as well as those receiving assistance in programs funded entirely with state funds (if those state funds are used to meet the TANF "maintenance of effort" requirement). Researchers and state officials have long recognized that such a participation requirement is not attainable because of the many legitimate reasons that some parents may be unable to fulfill the 35-hour a week requirement in any given month. For example, parents who must stay home for several days because they are ill or need to care for an ill child and parents who are simply waiting for a work program to begin will fail to meet the hourly requirements and the state will not be able to "count" them toward the work participation rates that month. This requirement was included in *neither* the House-passed reconciliation bill *nor* the bipartisan TANF reauthorization bill the Senate Finance Committee approved earlier this year.

Thus, the 90 percent participation requirement means that *any state that provides assistance to two-parent families will almost certainly fail to meet the work participation requirements and face fiscal penalties*. This could serve as a strong disincentive to states to provide aid to two-parent families and, ironically, take many states back to the old AFDC days when only single-parent families could get assistance. This is particularly ironic since other provisions in the TANF section of the conference agreement provide new funding for initiatives designed to encourage marriage.

**3. Child Care:** The conference report includes $1 billion in additional funding for child care, which is *$7.4 billion less* than CBO estimates to be the cost to states of meeting the new work requirements, and more than *$11 billion less* than what states will need both to meet the new work requirements and to ensure that their current child care programs for low-income working families that are not on TANF do not have to be scaled back as a result of the impact of inflation on child care costs. This means that the conference agreement effectively includes *no new funding* for states either to help meet the intensified work requirements that will be imposed upon them or to provide child care for children whose parents are now required to participate in work programs.

To come up with the funds to meet the new work requirements and provide child care for the children of mothers placed in these expanded work programs, many states will have little alternative but to scale back child care slots for working poor families not on welfare, and shift those slots to TANF families instead. As a result of the under-funding of child care in the conference agreement, we estimate that in 2010, *some 255,000 fewer children in low-income working families not on TANF will receive child care assistance than received such assistance in 2004***.**

To be sure, the $1 billion in child care funding in the conference agreement is higher than the $500 million in the House-passed bill. It also is $5 billion lower than the amount included for child care in the bipartisan TANF legislation approved by the Senate Finance Committee earlier this year that included more modest changes in federal work mandates on states.

**4. SSI:** Under the conference agreement, poor individuals with disabilities who have waited months for the Social Security Administration to review and approve their applications for SSI (a common occurrence in SSI), and who consequently are owed more than three months of back benefits, would have to receive these benefits in installments that could stretch out over the course of a year. The first installment would include no more than three months of back benefits. By contrast, under current law, most such disabled individuals receive their back benefits in a single lump sum payment. Individuals owed more than 12 months' worth of benefits receive benefits in installments, but the first installment is equal to 12 months of benefits.

This provision of the conference agreement means many poor SSI recipients with disabilities would have to wait longer for benefits they are owed, making it more difficult for them to pay off arrears in bills that have built up during the period when they were unable to work due to their disability but were not receiving any SSI benefits because SSA was still processing their application. Under the conference agreement, some poor individuals with disabilities could die before receiving the full back benefits they are owed. (With two minor exceptions, if a person dies before being paid SSI benefits they are owed, the SSI benefits are not paid to the person's relatives or estate. These back benefits are not even available to help family members pay for funeral costs.)

This SSI provision is largely a budget gimmick; it would make most of the affected beneficiaries wait longer for the benefits they are owed, thereby shifting some SSI costs from one year to the next and providing savings in the five-year budget "window." (Some "true" savings would be achieved, as well, as a result of some individuals dying before receiving the back benefits they are owed.) CBO estimates the savings from this provision at $425 million over five years. This is an example of a budget gimmick with an actual human cost, since many impoverished individuals with disabilities will face a more difficult time making ends meet as a result of the delays they will experience in receiving SSI payments they are owed.

**5. Foster Care:** The bill includes $343 million in net cuts in funding for the foster care program**,** including two cuts that will make it harder for some states to provide federally funded foster care benefits to certain relatives (often grandparents) who are raising children because their parents are unable to do so. This represents a cost-shift to these states, which will still need to provide assistance to these families to ensure that the children continue to be cared for. In some states, it also will represent a cut in the level of aid provided to these families.[6]

[6] In these states, the changes will make some low-income relatives who are caring for children ineligible for federal foster care benefits, pushing these families into the TNAF program instead. TANF benefit levels are significantly lower than foster care benefit levels.