



Fiscal Score HR 6364

Kidd's Stuttering Act

HR 6364, sponsored by Representative McDowell, is legislation intended to add stuttering to the Centers for Medicare & Medicaid Services (CMS) Child Core Set. CMS Child Core Set is the standardized set of health screenings used by states to monitor the health of children. The proposed legislation would require screening of children 2–6 years old and would require coverage of speech therapy under Medicaid and Children's Health Insurance Program (CHIP).

The Fiscal Lab's analysis of this provision finds that a majority of states already provide some form of stuttering coverage through Medicaid. The primary cost of the bill would then align to ensuring state parity of healthcare services provided for stuttering by requiring screening and speech therapy. Though the overall cost of providing speech fluency screening and therapy is costly, current costs are already born by Medicaid spending. Therefore, it is likely that the increased expenditure to ensure parity would be minimal and would not exceed the Fiscal Lab's de minimis threshold



HR 6364

Fiscal Years (Millions of dollars)

	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2026 – 2030	2026 – 2035
Total Increase or Decrease (-) in Deficit	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0
On Budget	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0
Off Budget	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0
Direct Spending (Outlays)	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0
Revenues	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0

Notes: At this time the Fiscal Lab does not believe the value will exceed \$1 billion for a 10-year window.

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To amend titles XI, XIX, and XXI of the Social Security Act with respect to screening for childhood onset fluency disorders, and to require coverage of certain speech therapy services under Medicaid and CHIP.

Final Score: Under \$1 billion—for 2026 to 2035

Summary: The Kidd's Stuttering Act amends the Social Security Act to (1) add stuttering screening to the CMS Child Core Set, (2) require fluency disorder screening at Medicaid well-child visits for children ages 2–6, and (3) mandate Medicaid and CHIP coverage of speech therapy for stuttering, ensuring parity to other speech therapy services already covered by the state. These provisions would take effect January 1, 2027.

The direct cost to the federal government would be due to the expansion of Medicaid and CHIP to cover the increased screening and speech therapies, ensuring parity of healthcare services across all states. The amendment of the CMS Child Core Set would be a regulatory update, and those costs would likely be absorbed by the necessary agencies, and any additional spending would be minimal.

As noted by the NIH, approximately 5–10 percent of children develop a stutter between the ages of 2 and 6. However, in most cases, the stutter is temporary and lasts only a few weeks to several years because many children are still early in their development of language skills during these ages. Persistent stuttering impacts approximately 1 percent of the population, as noted by the Stuttering Foundation. Only 5 percent of children go through a period of stuttering that lasts longer than six months, and approximately 75 percent of those children recover.

The American Speech-Language-Hearing Association (ASHA) notes that the 2026 Medicare Fee schedule for speech-language pathologists lists a 2026 per-session cost of \$133.27—up approximately 2 percent from the 2025 values—for evaluating speech fluency. The cost of ongoing speech therapy can be higher and is highlighted in Table 2. However, the federal government only pays a portion of the total cost. The Kaiser Family Foundation provides the “FY2027 Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier” that can help estimate potential costs to the federal government.

The state of Tennessee pursued a speech therapy provision in SB 231. The original version of the Tennessee bill was designed to provide health plans that cover speech therapy for stuttering. This imposed a fiscal cost of \$3.07 million in general state funds and another \$1.60 million in federal funds. However, the enacted version was much narrower and only implemented a study of the feasibility of implementing the requirements for speech therapy, ultimately moving away from stuttering coverage—which would align with Kentucky's SB 111—toward a study-first approach. Kentucky's SB 111 provided stuttering coverage for habilitative and rehabilitative speech therapy, providing coverage for the disorder regardless of whether it is classified as developmental or not. The Kentucky bill provided broad coverage with no annual benefit cap, no limit on visits, and no exclusions as to the cause of stuttering allowing for in-person and telehealth speech therapy.

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One area to be mindful of is the requirement for parity provision in healthcare, ensuring each state provides a similar standard of care. The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit already requires Medicaid coverage of medically necessary services for children, and the parity floor would only matter in states that currently have differential limits on stuttering versus other disorders. Screening costs would be negligible since they fit into existing well-child visits. This could have a minor increased cost to make sure that standards of care are consistent through regulation or supervision by comparing each state. This would impose some regulatory costs to review each state's plans with regard to stuttering screening and therapy costs to ensure there is equality across each state's plan. However, it is unlikely that the costs would exceed \$100 million a year since most states have some version of speech therapy provided.

Overall, based upon the data the Fiscal Lab was able to collect, and based upon the original score of Tennessee SB 231, the fiscal impact would be minimal to the federal government. Likewise, the additional regulatory burden would also be minimal and likely absorbed by the existing budgets of these agencies. Given the available data and the reasonable assumptions imposed by the Fiscal Lab, it is unlikely that implementing this provision federally would exceed the \$100 million threshold for a single year, or the \$1 billion threshold for a 10-year basis, falling below our de minimis threshold for a detailed score.

Additional Notes:

The below write-up analyzes the potential overall cost to the federal government of stuttering screening and therapy. However, this total cost includes the existing cost to the federal government. As noted, the following provision focuses on parity and would likely remain below \$1 billion over a 10-year window.

If the Fiscal Lab assumes 5 percent of the children between the ages of 2 and 6 are affected by stuttering, that would mean there are fewer than 1 million children in the current year needing speech therapy. To estimate the cost to the federal government of this legislation, a FMAP weighted average of 57.9 percent across US states, weighting based on population, can be used. Therefore, with approximately 1 million children diagnosed with stuttering, at a cost of \$133.27 for a session of speech fluency evaluation per child, and a federal share of 57.9 percent of the cost, we can estimate an approximate cost of \$71.7 million in the first year of the program. The cost of prolonged therapy would likely be greater with each additional session necessary. The Fiscal Lab assumes that 5 percent of the population would undergo speech fluency diagnosis, which would happen during a separate evaluation session outside a basic well-child visit, as it is unlikely children without symptoms would undergo further evaluation requiring the formal diagnosis.

Table 1: Estimated child population and evaluation of speech therapy costs

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Fiscal Year	Estimated Children 2-6 (millions)	Projected Annual Growth Rate	5% of Children for Speech Therapy	ASHA Medicare Fee Schedule (2% growth)	Estimated Federal Cost (57.9% FMAP) (millions)
2026	18.58	0.00%	929,000	\$133.27	\$71.68
2027	18.58	-0.18%	929,000	\$135.94	\$73.12
2028	18.55	-0.18%	928,000	\$138.65	\$74.50
2029	18.52	-0.18%	926,000	\$141.43	\$75.83
2030	18.48	0.36%	924,000	\$144.26	\$77.18
2031	18.55	0.00%	928,000	\$147.14	\$79.06
2032	18.55	0.09%	928,000	\$150.08	\$80.64
2033	18.57	0.00%	928,000	\$153.09	\$82.25
2034	18.57	0.00%	928,000	\$156.15	\$83.90
2035	18.57	0.00%	928,000	\$159.27	\$85.58

Table 1 estimates the approximate cost of diagnosing speech therapy. However, once diagnosed, a child may require prolonged treatment that could approximate the following payout schedule in Table 2.

Table 2: Potential treatment pattern

Treatment Pattern	Example Assumptions	Annual Private-Pay Cost
Short Course	12 sessions/year × \$150	\$1,800
Moderate Course	24 sessions/year × \$175	\$4,200
Intensive/Prolonged Course	40 sessions/year × \$200	\$8,000

The Fiscal Lab assumes that approximately 75 percent of children affected by stuttering would require a “short course” of treatment, as defined in Table 2, meaning they would require roughly 12 sessions over six months. The Fiscal Lab assumes a further 20 percent of the population would undergo a “moderate course” of treatment, with the remaining 5 percent of the population going for a more “intensive / prolonged course” of treatment. Within the estimated costs, the Fiscal Lab applied the 57.9 percent FMAP on the portion that the federal government would be responsible for. Additionally, aligning to the cost of speech fluency diagnosis, the treatment costs are grown at 2 percent in each subsequent year.

Table 3: Estimated speech therapy treatment costs

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Fiscal Year	Children for Speech Therapy	Short Course Treatment Cost (75% - millions)	Moderate Course Treatment Cost (20% - millions)	Intensive Course Treatment Cost (5% - millions)	Total Cost (57.9% FMAP) (Millions)
2026	929,000	\$1,254.15	\$780.36	\$371.60	\$1,393.14
2027	929,000	\$1,279.23	\$795.97	\$379.03	\$1,421.00
2028	928,000	\$1,303.41	\$811.01	\$386.20	\$1,447.86
2029	926,000	\$1,326.62	\$825.45	\$393.07	\$1,473.63
2030	924,000	\$1,350.23	\$840.14	\$400.07	\$1,499.86
2031	928,000	\$1,383.19	\$860.65	\$409.83	\$1,536.48
2032	928,000	\$1,410.86	\$877.87	\$418.03	\$1,567.21
2033	928,000	\$1,439.07	\$895.42	\$426.39	\$1,598.55
2034	928,000	\$1,467.85	\$913.33	\$434.92	\$1,630.53
2035	928,000	\$1,497.21	\$931.60	\$443.62	\$1,663.14

The cost of speech therapy would then be estimated at \$15.2 billion over a 10-year window, as identified by Table 3. This would be in addition to the \$783.7 million to diagnose speech issues, bringing an approximate total cost to \$16.0 billion. However, a majority of these costs are already absorbed by Medicaid and therefore would not be a new level of spending.

Source(s):

[Kentucky General Assembly, Senate Bill 111, Legislative Research Commission, accessed on May 15, 2026.](#)

[Tennessee General Assembly, Senate Bill 231, House Bill 296, An ACT to amend Tennessee Code Annotated, Title 8; Title 56; Title 63; and Title 71, relative to speech therapy, accessed on May 15, 2026.](#)

[Tennessee General Assembly, Fiscal Review Committee, SB 231 – HB 296, Fiscal Note, accessed on May 15, 2026.](#)

[National Institute of Health, National Institute on Deafness and Other Communication Disorders, Stuttering, accessed on May 18, 2026.](#)

[The Stuttering Foundation, Prevalence of Stuttering, accessed on May 18, 2026.](#)

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[American Speech-Language-Hearing Association \(ASHA\), 2026 Medicare Fee Schedule for Speech-Language Pathologists.](#)

[Kaiser Family Foundation \(KFF\), Federal Medical Assistance Percentage \(FMAP\) for Medicaid and Multiplier, FY2027, accessed on May 18, 2026.](#)

[ChildSTATS, Forum on Child and Family Statistics, POP1 Child population: Number of children \(in millions\) ages 0–17 in the United States by age, 1950–2022 and projected 2023–2050, accessed on May 18, 2026.](#)

Modeling Used: [None / describe model]

To estimate the population of children between 2 and 6 years old, we took 4/6th of the 0–5 population and 1/6th of the 6–11 population as reported by ChildSTATS.gov.

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