CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

April 26, 2006

S. 1057
Indian Health Care Improvement Act Amendments of 2005

As reported by the Senate Committee on Indian Affairs on March 16, 2006

SUMMARY

S. 1057 would authorize the appropriation of such sums as necessary through 2015 for the Indian Health Care Improvement Act, the primary authorizing legislation for the Indian Health Service (IHS). The bill also contains specific authorizations for a program to encourage Indians to pursue careers related to behavioral health, a demonstration project to provide suicide prevention services, a commission on Indian health care, and administrative costs for a new nonprofit corporation. In addition, the bill also would affect direct spending, primarily through provisions affecting the Medicaid program.

CBO estimates that implementing S. 1057 would cost $2.6 billion in 2007 and $30.4 billion over the 2007-2016 period, assuming appropriation of the necessary amounts. We also estimate that enacting the bill would increase direct spending by $27 million in 2007, by $162 million over the 2007-2011 period, and by $398 million over the 2007-2016 period.

S. 1057's mandatory costs would continue to rise in subsequent years due to steady growth in the cost of health care services and the size of the Indian population. As a result, pursuant to section 407 of H. Con. Res. 95 (the Concurrent Resolution on the Budget, Fiscal Year 2006), CBO estimates that enacting the bill would cause an increase in direct spending greater than $5 billion in at least one of the 10-year periods from 2016 to 2055.

S. 1057 would preempt state licensing laws in certain cases, and this preemption would be an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA); however, CBO estimates that the costs of that mandate would be small and would not approach the threshold established in UMRA ($64 million in 2006, adjusted annually for inflation). The bill also would place new requirements on Medicaid and the State Children's Health Insurance Program (SCHIP) that would result in additional spending by states of about $95 million over the 2007-2011 period. Other provisions of the bill would establish new or expand existing programs for Indian health care. This bill contains no private-sector mandates as defined in UMRA.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of S. 1057 is shown in Table 1. The costs of this legislation fall within budget function 550 (health).

TABLE 1. ESTIMATED BUDGETARY EFFECTS OF S. 1057

	By Fiscal Year, in Millions of Dollars									
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
CHANGES IN SPENDING SUBJECT TO APPROPRIATION										
Estimated Authorization Level	3,127	3,194	3,267	3,340	3,416	3,495	3,575	3,658	3,744	1
Estimated Outlays	2,575	3,005	3,167	3,308	3,382	3,460	3,540	3,621	3,706	636
CHANGES IN DIRECT SPENDING										
Estimated Budget Authority	26	28	33	34	39	39	45	45	50	56
Estimated Outlays	27	29	33	34	39	39	45	45	50	57

BASIS OF ESTIMATE

For the purpose of this estimate, CBO assumes that S. 1057 would be enacted near the start of fiscal year 2007 and that the necessary amounts will be appropriated for each fiscal year.

Spending Subject to Appropriation

The estimated effects of S. 1057 on spending subject to appropriation are detailed in Table 2.

Existing Indian Health Service Activities. S. 1057 would authorize the appropriation of such sums as necessary for the Indian Health Service through 2015. The agency's responsibilities under the bill would be broadly similar to those in current law. In 2006, the agency received an appropriation just over $3 billion. CBO's estimate of the authorized level for IHS programs is the appropriated amount for 2006 adjusted for inflation in later years. The estimated outlays reflect historical spending patterns for IHS activities.

Recruitment Program for Behavioral Health Careers. Section 105 of the bill would authorize the appropriation of $2.7 million annually through 2015 for grants to develop and maintain programs that encourage Indians to pursue careers in a field relate to behavioral health. Assuming the appropriation of the authorized amounts, CBO estimates that

implementing this provision would cost $2 million in 2007 and $24 million over the 2007-2016 period.

TABLE 2. ESTIMATED EFFECTS OF S. 1057 ON DISCRETIONARY SPENDING

	By Fiscal Year, in Millions of Dollars										
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
IHS Spending Under Current Law [a]											
Budget Authority	3,044	0	0	0	0	0	0	0	0	0	0
Estimated Outlays	3,042	522	160	73	2	0	0	0	0	0	0
Proposed Changes:											
Existing Indian Health Service Activities											
Estimated Authorization Level	0	3,117	3,188	3,261	3,336	3,412	3,491	3,571	3,654	3,740	0
Estimated Outlays	0	2,571	2,998	3,160	3,303	3,378	3,456	3,536	3,617	3,702	634
Recruitment Program for Behavioral Health Careers											
Authorization Level	0	3	3	3	3	3	3	3	3	3	0
Estimated Outlays	0	2	3	3	3	3	3	3	3	3	1
Mental Health Demonstration Project											
Authorization Level	0	2	2	2	0	0	0	0	0	0	0
Estimated Outlays	0	*	1	2	1	*	0	0	0	0	0
Commission on Indian Health Care											
Authorization Level	0	4	0	0	0	0	0	0	0	0	0
Estimated Outlays	0	1	2	1	0	0	0	0	0	0	0
Native American Health and Wellness Foundation											
Authorization Level	0	1	1	1	1	1	1	1	1	1	1
Estimated Outlays	0	*	1	1	1	1	1	1	1	1	1
Total Changes in Spending Subject to Appropriation											
Estimated Authorization Level	0	3,127	3,194	3,267	3,340	3,416	3,495	3,575	3,658	3,744	1
Estimated Outlays	0	2,575	3,005	3,167	3,308	3,382	3,460	3,540	3,621	3,706	636
Spending Under S. 1057											
Estimated Authorization Level [a]	3,044	3,127	3,194	3,267	3,340	3,416	3,495	3,575	3,658	3,744	1
Estimated Outlays	3,042	3,097	3,165	3,240	3,310	3,382	3,460	3,540	3,621	3,706	636

NOTES: * = Less than $500,000.

Components may not sum to totals because of rounding.

a. The 2006 level is the amount appropriated for that year for IHS.

Mental Health Demonstration Project. Section 708 would authorize the appropriation of $1.5 million annually for fiscal years 2007 through 2009 for grants to examine the feasibility of using telecommunication technology to provide suicide prevention services to Indians. Assuming the appropriation of the authorized amounts, CBO estimates that implementing

this provision would cost less than $500,000 in 2007 and about $4 million over the 2007-2011 period.

Commission on Indian Health Care. Section 814 would authorize the appropriation of $4 million for a commission that would examine how the federal government provides health care services to Indians. The members of the commission would have to be appointed within eight months of the bill's enactment and would be required to submit a final report to the Congress no later than 18 months after that. Assuming the appropriation of the authorized amount, CBO estimates that implementing this provision would cost $1 million in 2007, $2 million in 2008, and $1 million in 2009.

Native American Health and Wellness Foundation. S. 1057 would establish a charitable and nonprofit corporation called the Native American Health and Wellness Foundation to assist federal, state, tribal, and other entities in efforts to further health and wellness activities and opportunities for Indians. The bill would authorize the appropriation of $500,000 annually for the foundation's administrative expenses; this amount would be adjusted in later years for inflation. Assuming the appropriation of the authorized amounts, CBO estimates that implementing this provision would cost about $400,000 in 2007 and $6 million over the 2007-2016 period.

Direct Spending

S. 1057 contains several provisions, primarily related to the Medicaid program, that would affect direct spending. The bill's estimated effects on direct spending are shown in Table 3. Overall, CBO estimates that enacting the bill would increase direct spending by $27 million in 2007 and $398 million over the 2007-2016 period.

The effects of each provision are discussed in more detail below. IHS-funded health programs are commonly divided into three groups: those operated directly by the Indian Health Service, those operated by tribes and tribal organizations under self-governance agreements, and those operated by urban Indian organizations. For this estimate, they are referred to collectively as Indian health programs.

Consultation with Indian Health Programs. Section 409 would encourage state Medicaid programs to consult regularly with Indian health programs on outstanding Medicaid issues by allowing states to receive federal matching funds for the cost of those consultations. Those costs would be treated as an administrative expense under Medicaid and divided equally between the federal government and the states. CBO anticipates that a small number of states would take advantage of this provision, increasing federal Medicaid spending by less than $500,000 in 2007 and by $7 million over the 2007-2016 period.

TABLE 3. ESTIMATED EFFECTS OF S. 1057 ON DIRECT SPENDING

	By Fiscal Year, in Millions of Dollars									
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Consultation with Indian Health Programs										
Estimated Budget Authority	*	*	1	1	1	1	1	1	1	1
Estimated Outlays	*	*	1	1	1	1	1	1	1	1
Exemption from Cost Sharing and Premiums										
Medicaid										
Estimated Budget Authority	25	25	30	30	35	35	40	40	45	50
Estimated Outlays	25	25	30	30	35	35	40	40	45	50
SCHIP										
Budget Authority	0	0	0	0	0	0	0	0	0	0
Estimated Outlays	1	1	*	-1	*	*	*	*	*	*
Medicaid Managed Care Provisions										
Estimated Budget Authority	1	2	2	3	3	3	4	4	4	5
Estimated Outlays	1	2	2	3	3	3	4	4	4	5
Scholarship and Loan Repayment Recovery Fund										
Estimated Budget Authority	*	*	*	*	*	*	*	*	*	*
Estimated Outlays	*	*	*	*	*	*	*	*	*	*
Total Changes in Direct Spending										
Estimated Budget Authority	26	28	33	34	39	39	45	45	50	56
Estimated Outlays	27	29	33	34	39	39	45	45	50	57

NOTES: Components may not sum to totals because of rounding. SCHIP is the State Children's Health Insurance Program.

* = Costs or savings of less than $500,000.

Exemption from Cost Sharing and Premiums. Section 412 would prohibit Medicaid and the State Children's Health Insurance Program from charging any type of cost sharing or premium to Indians enrolled in those programs. The provision also would prohibit states from reducing payments for Medicaid and SCHIP services provided by Indian health programs by the amount of cost sharing that Indians otherwise would pay.

Medicaid. CBO anticipates that this provision's budgetary effect would stem largely from eliminating cost sharing for Medicaid services that are not provided by Indian health programs. Current law already prohibits Indian health programs from charging cost sharing to Indians who use their services. In addition, Medicaid pays almost all facilities operated by IHS and tribes based on an all-inclusive rate that is not reduced to account for any cost sharing that Indians would otherwise have to pay. Very few states charge premiums to their Medicaid enrollees.

Using Medicaid administrative data, CBO estimates that about 850,000 Indians will have Medicaid coverage in 2007, and that federal spending on benefits for them (beyond those provided by Indian health programs) will total about $1.9 billion. However, the amount of spending that would be affected by the bill would be much smaller—between 10 and 20 percent of total spending—because states typically impose cost sharing on only a limited number of acute care services such as physician visits and prescription drugs. Medicaid also limits the extent to which states may impose cost sharing on emergency services and services for pregnant women and most children.

For the affected spending, CBO assumes that cost sharing paid by individuals equals 2 percent of total spending—Medicaid law limits cost sharing to nominal amounts—and that eliminating cost sharing would increase total spending by about 5 percent as individuals consume more services. Overall, CBO estimates that the provision would increase federal Medicaid spending by $25 million in 2007 and by $355 million over the 2007-2016 period.

State Children's Health Insurance Program. SCHIP regulations already prohibit states from charging cost sharing or premiums to Indian children enrolled in the program. As a result, the provision's impact on SCHIP spending largely reflects higher payments to Indian health programs and the use of additional services by adult enrollees that some states cover in waiver programs. CBO estimates that the additional spending would total $2 million over the 2007-2016 period. The provision's effects would be limited in later years because total funding for the program is capped.

Medicaid Managed Care Provisions. Section 413 would make several changes to improve the ability of Indian health programs to receive payments for Indians who receive Medicaid benefits through managed care arrangements. Those changes include:

- Managed care organizations (MCOs) would have to pay Indian health programs at least the rates used for non-preferred providers. States also would have the option of making those payments directly to Indian health programs.

- MCOs would have to accept claims submitted by Indian health programs instead of requiring enrollees to submit claims personally.

- Some requirements that MCOs must now meet to participate in Medicaid would be waived or modified for Indian health programs that seek to operate as MCOs. (For example, MCOs run by Indian health programs would be able to limit enrollment to Indians only.)

- States would be required to offer contracts to Indian health programs seeking to operate their own MCOs.

Based on administrative data on Medicaid enrollment and spending for Indians who receive benefits via managed care, CBO estimates that those provisions would increase federal Medicaid spending by $1 million in 2007 and $31 million over the 2007-2016 period. We anticipate that the additional costs would be relatively modest because some states already use similar rules in their Medicaid managed care programs and Indian health programs would have a limited interest in participating as MCOs.

Scholarship and Loan Repayment Recovery Fund. Section 111 would allow the Secretary of Health and Human Services to spend amounts collected for breach of contract from recipients of certain IHS scholarships. Under current law, those funds are deposited in the Treasury and not spent. Because the Secretary's ability to spend those funds would not be subject to appropriation, the provision would increase direct spending. Based on historical information from IHS, CBO estimated that the provision would increase spending by less than $500,000 a year and about $4 million over the 2007-2016 period.

ESTIMATED LONG-TERM DIRECT SPENDING EFFECTS

CBO assumes that S. 1057's mandatory costs would increase by 8 percent annually after 2016 due to steady growth in the cost of health care services and the size of the Indian population. As a result, pursuant to section 407 of H. Con. Res. 95 (the Concurrent Resolution on the Budget, Fiscal Year 2006), CBO estimates that enacting the bill would cause an increase in direct spending greater than $5 billion in at least one of the 10-year periods from 2016 to 2055.

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

Intergovernmental Mandates

S. 1057 would preempt state licensing laws in cases where a health care professional is licensed in one state but is performing services in another state under a contract or compact with a tribal health program. This preemption would be an intergovernmental mandate as defined in the UMRA; however, CBO estimates that the loss of any licensing fees resulting from the mandate would be small and would not approach the threshold established in UMRA ($64 million in 2006, adjusted annually for inflation).

Other Impacts

S. 1057 would reauthorize and expand grant and assistance programs available to Indian tribes, tribal organizations, and urban Indian organizations for a range of health care programs, including prevention, treatment, and ongoing care. The bill also would allow IHS and tribal entities to share facilities, and it would authorize joint ventures between IHS and Indian tribes or tribal organizations for the construction and operation of health facilities. The bill would authorize funding for a variety of health services including hospice care, long-term care, public health services, and home and community-based services.

The bill would prohibit states from charging cost sharing or premiums to Indians enrolled in the Medicaid or SCHIP programs. The bill also would require states that operate managed care systems within their Medicaid programs to enter into agreements with Indian health programs that operate managed care systems. CBO estimates that these requirements would result in additional spending by states of about $95 million over the 2007-2011 period. Some tribal entities, particularly those operating managed care systems, may realize some savings as a result of these provisions.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

This bill contains no private-sector mandates as defined in UMRA.

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